

No. 300  
10.48

FILED JUN 30 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20606

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 544 Registrar's No. 1269

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. CITY <u>St. Louis</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> |   |
| b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <u>Kirkwood</u> |  | c. CITY OR TOWN <u>Manchester</u>   | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (In this place) <u>7 days</u>   |  | • STREET ADDRESS (If rural, give location) <u>Dietrich Rd., Box 233</u>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>                          |  |   |   |

|                                     |                         |                       |                        |   |
|-------------------------------------|-------------------------|-----------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>PERCY</u> | b. (Middle) <u>C.</u> | c. (Last) <u>JONES</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>June 2, 1955</u> |
|-------------------------------------|-------------------------|-----------------------|------------------------|---|

|                    |                               |   |                                       |   |                              |   |
|--------------------|-------------------------------|---|---------------------------------------|---|------------------------------|---|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>June 24, 1875</u> | 9. AGE (In years last birthday) <u>79</u> | IF UNDER 1 YEAR Months _____ | IF UNDER 10 HRS. Hours _____ Min. _____ |
|--------------------|-------------------------------|---|---------------------------------------|---|------------------------------|---|

|   |   |   |  |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Banker</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bank Executive</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|---|---|--|

|   |  |   |
|---|--|---|
| 13a. FATHER'S NAME <u>Peyton C. Jones</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Ann Kick</u> | 14. NAME OF HUSBAND OR WIFE <u>Kathryn McMullen Jones</u> |
|---|--|---|

|  |                                     |  |                              |
|--|-------------------------------------|--|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Kathryn Jones</u> | ADDRESS <u>Dietrich Road</u> |
|--|-------------------------------------|--|------------------------------|

|   |  |  |                                  |
|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Thrombosis</u>   |  | <u>1 day</u>                     |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Myocardial Infarction</u><br>DUE TO (c) _____ |  | <u>1 day</u>                     |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>  |  |  |                                  |

|                              |  |  |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION <u>None</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|--|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>U201</u> |
|--|--|---|

|   |  |                                  |
|---|--|----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |
|---|--|----------------------------------|

22. I hereby certify that I attended the deceased from 5/22, 1955, to 6/2, 1955, that I last saw the deceased alive on 6/1, 1955, and that death occurred at 7:15A m., from the causes and on the date stated above.

|   |  |                                      |
|---|--|--------------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Frank Catanzaro, M.D.</u> | 23b. ADDRESS <u>Missouri Theatre Bldg.</u> | 23c. DATE SIGNED <u>June 3, 1955</u> |
|---|--|--------------------------------------|

|  |                               |  |  |
|--|-------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>June 4, 1955</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> |
|--|-------------------------------|--|--|

|  |  |  |                                 |
|--|--|--|---------------------------------|
| DATE REC'D BY LOCAL REG. <u>6/3/55</u> | REGISTRAR'S SIGNATURE <u>Herbert R. Dombke, M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Stock Mortuaries</u> | ADDRESS <u>889 S. Brentwood</u> |
|--|--|--|---------------------------------|

g.s. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr Frank Patton  
429 Mission Street Bldg.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Frank G. Patton*.....

Licensed Embalmer No. *300*.....

P. O. Address *2117 E. 1st*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**