

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23945**
Registrar's No. **6304**

FILED AUG 15 1955
BIRTH NO. **601A2-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY U		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2299	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis 0		c. LENGTH OF STAY (in this place) 0	c. CITY OR TOWN ST. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION: Lutheran Hospital		e. STREET ADDRESS (If rural, give location) 23 2644 ANN	
3. NAME OF DECEASED (Type or Print) a. (First) BERNARD b. (Middle) — c. (Last) JONES		4. DATE OF DEATH (Month) (Day) (Year) 7-21-55	
5. SEX Boy	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Newborn 0	8. DATE OF BIRTH 7-20-55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 7 IF UNDER 1 YEAR Months 25 IF UNDER 12 HRS. Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) ST. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY 0	
13a. FATHER'S NAME Charles Frank Jones		13b. MOTHER'S MAIDEN NAME Laura Bernice Munda	14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lutheran Hospital 2646 Belmont
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) atelectasis bilateral ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) — DUE TO (c) — II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prematurity (26 weeks)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7625	
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 7-20-1955 , to 7-21-1955 , that I last saw the deceased alive on _____, 19____, and that death occurred at 1:20 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Hugh P. Smith MD (Degree or title)		23b. ADDRESS 607 N. Grand	23c. DATE SIGNED 7-21-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/22/55	24c. NAME OF CEMETERY OR CREMATORY VAHALLA	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri Mo.
DATE REC'D BY LOCAL REG. JUL 22 1955		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette Ave.	

mgs (Licensed Embalmer's Statement on Reverse Side)

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

No Embalming
Signed.....
E. J. Schurer

Licensed Embalmer No.....

P. O. Address.....

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.