

FILED AUG 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23951-**
6522
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1009**

| | | | | | |
|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE | | b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) | | c. CITY OR TOWN | | d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. LENGTH OF STAY (In this place) | | STREET ADDRESS (If rural, give location) | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | 21 | | 3026 ^{1/2} Delmar | |

| | | | | | |
|--|------------------|--|--|---|------------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | |
| a. (First) | b. (Middle) | c. (Last) | 7 | 24 | 55 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR |
| Female | Negro | Married | Aug. 23, 1924 | 30 | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (City and State or Foreign Country) | |
| Housewife | | Housewife | | W. Va. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | |
| U.S.A. | | David Snow | | | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| Clyde Jones | | no | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS | | | |
| none | | Charles Bennett 3026 ^{1/2} Delmar | | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | Gunshot wound of brain | | | |
| *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | II. OTHER SIGNIFICANT CONTRIBUTING CONDITIONS | | | |
| | | with intracranial hemorrhage | | | |
| | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | |
| | | in with intracranial hemorrhage suffered when shot with gun in the hands of one Clyde Jones. (col) in home at 3026 ^{1/2} Delmar around 11:45 am | | | |
| | | DUE TO (c) | | | |
| | | Conditions contributing to the death not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | July 24, 1955 | | Homicide | |
| 21a. ACCIDENT OR 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) | |
| Homicide | | Home | | St. Louis Mo 981X | |
| 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? | |
| July 24 5:10 PM | | WORK | | | |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:55 PM., from the causes and on the date stated above.

| | | | | | |
|---|--|--|--|------------------------------------|--|
| 23a. SIGNATURE | | 23b. ADDRESS | | 23c. DATE SIGNED | |
| Patrick C. Taylor Carraway | | 1300 Clark | | 7.29.55. | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7.30.55 | | Oakdale | |
| 24d. LOCATION (City, town, or county) (State) | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | | |
| Mo. | | W. A. H. Burk 3506 Franklin | | | |

DATE REC'D BY LOCAL REG. JUL 29 1955

REGISTRAR'S SIGNATURE: *Charles Smith*

FUNERAL DIRECTOR'S SIGNATURE ADDRESS: *W. A. H. Burk 3506 Franklin Mo.*

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Licensed Embalmer No. 42

P. O. Address.....
Bellevue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.