

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27832

FILED SEP 8 1955

State File No. 7419
Registrar's No.

BIRTH NO. 60095-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		d. STREET ADDRESS (If rural, give location) 11 4472 Cook Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) Jones b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) July 29 1955	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ---	8. DATE OF BIRTH July 29 1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? 0	
13a. FATHER'S NAME Arthur Ulysees Jones		13b. MOTHER'S MAIDEN NAME Flora Louise Taylor	
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) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT'S SIGNATURE OR NAME Flora Louise Jones		ADDRESS 4472 Cook St. Louis	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gestation not compatible with life ANTECEDENT CAUSES Prematurity 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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? 776 A			
22. I hereby certify that I attended the deceased from July 29, 1955 , to July 29, 1955 , that I last saw the deceased alive on July 29, 1955 , and that death occurred at 11:00 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. B. Ballou M.D.		23b. ADDRESS 6305 Kingshighway	
23c. DATE SIGNED 7-30-55			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 8-31-55	
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. AUG 24 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Rawland Abee		ADDRESS 4104 Manchester	

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.