

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File # **81069**

FILED SEP 22 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO **318** PRIMARY REG. DIST. NO **1003** Registrar's No. **6994**

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS, MO</b>		2. USUAL RESIDENCE (Where deceased lived? If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY OR TOWN <b>SAINT LOUIS MO</b>	c. LENGTH OF STAY (In this place or township) <b>9 HRS</b>	c. CITY OR TOWN <b>SAINT LOUIS MO</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CHILDREN'S</b>		STREET ADDRESS (If rural, give location) <b>1349 No. Florissant Rd</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>JOYCE</b> b. (Middle) <b>ELAINE</b> c. (Last) <b>JONES</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>8-9-55</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>7-4-55</b>	9. AGE (In years last birthday) <b>1</b>	10. MONTHS <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS, MO</b>	
				12. CITIZEN OF WHAT COUNTRY <b>USA</b>	

13a. FATHER'S NAME <b>THOMAS JONES</b>	13b. MOTHER'S MAIDEN NAME <b>ALENE BLANKSHIP</b>	14. NAME OF HUSBAND OR WIFE
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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 <b>J. Egan</b>	ADDRESS <b>500 S Kings Highway</b>
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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		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumothorax, left</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Brachopleural fistula + lung Abscess days</b> DUE TO (c) <b>Staphylococcal Sepsis + Pneumonia days</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>8/8/55</b>	19b. MAJOR FINDINGS OF OPERATION <b>Tracheotomy and Closed pleural drainage</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <b>518X</b>	
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 **8-8**, 19**55**, to **8-9**, 19**55**, that I last saw the deceased alive on **8-9**, 19**55** and that death occurred at **6:35 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. H. Middalkamp M.D.</b>	(Degree or title)	23b. ADDRESS <b>500 S Kings Highway</b>	23c. DATE SIGNED <b>8/19/55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>8/11/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>
DATE REC'D BY LOCAL REG. <b>AUG 10 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Drehmann-Horral</b> ADDRESS <b>4905 Union Blvd</b>	

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

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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.. *Warren A. Cave* .....

Licensed Embalmer No. *35* .....

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.