

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34882

State File No.

FILED NOV 15 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9446**

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). | |
| b. CITY OR TOWN St. Louis, Missouri | | a. STATE ILLINOIS | b. COUNTY MARIAN |
| c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN CENTRALIA | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL | | e. STREET ADDRESS (If rural, give location) 1001 E. NOLEMAN St | |

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|-------------------------------------|---------------------------|------------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Shirley | b. (Middle) Ann | c. (Last) Jones | 4. DATE OF DEATH (Month) (Day) (Year) October 28, 1955 |
|-------------------------------------|---------------------------|------------------------|------------------------|---|

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|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|-------|------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH JAN. 30, 1941 | 9. AGE (In years last birthday) 14 | IF UNDER 1 YEAR Months | IF UNDER 2 HRS. Days | Hours | Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | 10b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL | 11. BIRTHPLACE (City and State or Foreign Country) CENTRALIA, ILLINOIS | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME HALLIE JONES | 13b. MOTHER'S MAIDEN NAME FAY IRENE WILLIAMSON | 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) No | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT'S SIGNATURE OR NAME Hallie Jones, Centralia Ill. | ADDRESS |
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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 6-8 Months |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Disseminated Carcinoma, primary site unknown | | |
| | ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 17/10/55 (a) Malignant Lymphoma (possibly disseminated) | | |
| DUE TO (c) | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
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| 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) |
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| 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? |
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22. I hereby certify that I attended the deceased from **8/8**, 19 **55**, to **10/28**, 19 **55**, that I last saw the deceased alive on **10/28**, 19 **55** and that death occurred at **9:00 a m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE FR Prindley | (Degree or title) M. D. | 23b. ADDRESS BARNES HOSPITAL | 23c. DATE SIGNED 10/28/55 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 24b. DATE 10/30/55 | 24c. NAME OF CEMETERY OR CREMATORY HILLREST MEMORIAL | 24d. LOCATION (City, town, or county) (State) CENTRALIA ILLINOIS |
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| DATE REC'D BY LOCAL REG. OCT 31 1955 | REGISTRAR'S SIGNATURE Carl Smith MD | 25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith MD | ADDRESS |
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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 Not Embalmed, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 754

P. O. Address E. H. ...

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.