

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

FILED DEC 2 1955

State File No. **38427**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10324**

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|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY _____  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>--- a. STATE <b>Missouri</b> --- b. COUNTY _____ |  |
| b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis, Mo.</b> |  | c. CITY OR TOWN <b>St. Louis</b>   | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) _____  |  | e. STREET ADDRESS (If rural, give location) <b>1320 Shawmut Pl.</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>                                     |  |  |  |

|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| <b>3. NAME OF DECEASED</b><br>(Type or Print)   |                                  |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year) |  |   |
| a. (First) <b>John</b>  | b. (Middle) <b>MMN</b>           | c. (Last) <b>Joiner</b>  | <b>Nov. 22, 1955</b>                         |  |   |
| <b>5. SEX</b><br>M  | <b>6. COLOR OR RACE</b><br>Negro | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify)<br>Married | <b>8. DATE OF BIRTH</b><br>3/22/1887         | <b>9. AGE</b> (In years last birthday)<br>68                                   | <b>10. IF UNDER 1 YEAR</b><br>Months _____ Days _____ |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Freight handler |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>                                 |  | <b>11. BIRTHPLACE</b> (City and State or Foreign Country)<br>Collinsville Ill. | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.         |

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|---|---|---|
| <b>13a. FATHER'S NAME</b><br>Moses Joiner | <b>13b. MOTHER'S MAIDEN NAME</b><br>Elizabeth ? | <b>14. NAME OF HUSBAND OR WIFE</b><br>Estella Joiner-1320 |
|---|---|---|

|   |   |  |  |                                    |
|---|---|--|--|------------------------------------|
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) No | <b>16. SOCIAL SECURITY NO.</b><br>499-03-9869 | <b>17. INFORMANT'S SIGNATURE OR NAME</b><br>Estella Joiner |  | <b>ADDRESS</b><br>1320 Shawmut Pl. |
|---|---|--|--|------------------------------------|

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| <b>18. CAUSE OF DEATH</b><br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.</i> | <b>MEDICAL CERTIFICATION</b>  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> |
|  | <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) Myocardial Infarction         |  |   |
|  | <b>ANTECEDENT CAUSES</b><br>DUE TO (b) Generalized Arteriosclerosis<br><br>DUE TO (c) _____ |  |   |
| <b>II. OTHER SIGNIFICANT CONDITIONS</b><br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |   |

|                               |   |  |
|-------------------------------|---|--|
| <b>19a. DATE OF OPERATION</b> | <b>19b. MAJOR FINDINGS OF OPERATION</b> | <b>20. AUTOPSY?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|-------------------------------|---|--|

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|---|--|--|
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)                 | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | <b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b><br>4201 |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ m. | <b>21e. INJURY OCCURRED</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | <b>21f. HOW DID INJURY OCCUR?</b>                              |

**22. I hereby certify that I attended the deceased from June 10, 1952, to Nov. 22, 1955, that I last saw the deceased alive on Sept. 28, 1955, and that death occurred at 9:15 a.m., from the causes and on the date stated above.**

|  |                             |  |                                     |
|--|-----------------------------|--|-------------------------------------|
| <b>23a. SIGNATURE</b><br><i>C. J. Hamilton, M.D.</i> | (Degree or title?)<br>M. D. | <b>23b. ADDRESS</b><br>BARNES HOSPITAL | <b>23c. DATE SIGNED</b><br>11/22/55 |
|--|-----------------------------|--|-------------------------------------|

|   |                              |  |  |
|---|------------------------------|--|--|
| <b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>Removal | <b>24b. DATE</b><br>11/28/55 | <b>24c. NAME OF CEMETERY OR CREMATORY</b><br>Washington Park | <b>24d. LOCATION</b> (City, town, or county) (State)<br>St. Louis County Mp. |
|---|------------------------------|--|--|

|  |  |  |                                   |
|--|--|--|-----------------------------------|
| <b>DATE REC'D BY LOCAL REG.</b><br>NOV 26 1955 | <b>REGISTRAR'S SIGNATURE</b><br><i>J. Earl Smith</i> | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br>GRANT JOHNSON | <b>ADDRESS</b><br>4352 Wash. Blvd |
|--|--|--|-----------------------------------|

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 *F. A. Green*.....

Licensed Embalmer No. *296*.....

P. O. Address *4214 Delmar*.....

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.