

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6712

State File No.

711

1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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 town) ST. LOUIS		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS		22%	
d. FULL NAME OF HOSPITAL OR INSTITUTION 773 AUBERT				d. STREET ADDRESS (If rural, give location) 773 AUBERT AVE.			
3. NAME OF DECEASED (Type or Print) a. (First) Michael		b. (Middle) _____		c. (Last) JONES		4. DATE OF DEATH (Month) (Day) (Year) 1-18-56	
5. SEX M		6. COLOR OR RACE G		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) CHILD		8. DATE OF BIRTH MAR 18 1949	
9. AGE (In years last birthday) 6		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		11. BIRTHPLACE (State or foreign country) ST LOUIS Mo.		12. CITIZEN OF WHAT COUNTRY? 0	
13a. FATHER'S NAME LESTER JONES		13b. MOTHER'S MAIDEN NAME NOLA SMITH		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Nola Smith 773 Aubert Ave			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suffocation by hanging ANTECEDENT CAUSES suffered which deceased Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (a) accidentally hanged himself DUE TO (b) or banister of house at II. OTHER SIGNIFICANT CONDITIONS 773 Aubert Avenue on January 18 1956 Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 25 pm.		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 18 56 8:15		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 02 E 936.022			
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 9:30 pm. from the causes and on the date stated above.							
23a. SIGNATURE Steph M. Jones				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 1/20/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-23-56		24c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM		24d. LOCATION (City, town, or county) (State) ST. LOUIS, CTY MO	
DATE REC'D BY LOCAL REG. JAN 21 1956		REGISTRAR'S SIGNATURE J. Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE A. F. Walters		ADDRESS 2707 Stoddard	

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
Student Embalmer

Signed *W. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine*

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