No. 300
10-48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18088

State File No. .....

FILED MAY 25 1956

BIRTH NO. 33780-56 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4083

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Louis Maternity

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 3025 North Whittier 210 10

3. NAME OF DECEASED (Type or Print)
a. (First)
b. (Middle)
c. (Last): Jones

4. DATE OF DEATH (Month) (Day) (Year): April 20 1956

5. SEX: Male 2

6. COLOR OR RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): --

8. DATE OF BIRTH: April 20 1956

9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 7 Min. 15

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 Mo

12. CITIZEN OF WHAT COUNTRY?: --

13a. FATHER'S NAME: Frank Ben Jones

13b. MOTHER'S MAIDEN NAME: Corinne Payne

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: Corinne Jones
ADDRESS: Above

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity: length of gestation not compatible c̄ life. — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs 15 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
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. 776X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 20, 1956, *to* April 20, 1956, *that I last saw the deceased alive on* April 20, 19 56 *and that death occurred at* 8:40 Am., *from the causes and on the date stated above.*

23a. SIGNATURE: J W Ballew (Degree or title) M.D

23b. ADDRESS: 630 S. Kingshighway

23c. DATE SIGNED: 4-23-56

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE: 4-30-56

24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: APR 25 1956

REGISTRAR'S SIGNATURE: J Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE: Rowland-Aker

ADDRESS: 4104 Manchester

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

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