

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21920

FILED JUN 25 1956

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State File No.

Registrar's No. 5676

BIRTH NO. _____		REG. DIST. NO. _____		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 OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Mary's Infirmary				e. STREET ADDRESS (If rural, give location) 4024 Fairfax			
3. NAME OF DECEASED (Type or Print) a. (First) Robert		b. (Middle) _____		c. (Last) Jones		4. DATE OF DEATH (Month) (Day) (Year) 6 12 56	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated		8. DATE OF BIRTH 4-15-1908	
9. AGE (In years last birthday) 48		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Mississippi	
11. BIRTHPLACE (City and State or Foreign Country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Dan Jones		13b. MOTHER'S MAIDEN NAME Della Smith	
13a. FATHER'S NAME Dan Jones		13b. MOTHER'S MAIDEN NAME Della Smith		14. NAME OF HUSBAND OR WIFE Separated		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
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. ?		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Pinkie Taylor 4030 A. Fairfax			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculous Meningitis ANTECEDENT CAUSES Tuberculous Peritonitis 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.				INTERVAL BETWEEN ONSET AND DEATH 7 wks. 4 wks.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION .010 x				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) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
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 5-19, 1956 , to 6-12, 1956 , that I last saw the deceased alive on 6-11, 1956 , and that death occurred at 7:30 A.M. m., from the causes and on the date stated above.							
23a. SIGNATURE A.B. Smith, M.D. (Degree or title)				23b. ADDRESS 11N Jefferson At Home		23c. DATE SIGNED 6-15-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-16-56		24c. NAME OF CEMETERY OR CREMATOR Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
DATE REC'D BY LOCAL REG. JUN 14 1956		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc 2820 Stoddard St.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc 2820 Stoddard St.	

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 *Fulton E. Cecil King*

Licensed Embalmer No. *4198*

P. O. Address *4912 Found*

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.