

STANDARD CERTIFICATE OF DEATH

FILED JUL 20 1956

25048

STATE FILE NUMBER

6048

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. 9 Hospital 30 hours MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN ST. LOUIS, MISSOURI	
c. FULL NAME OF (If not in Missouri, give location) HOSPITAL OR INSTITUTION HOSPITAL #1.		d. STREET ADDRESS (If outside, give location) 1211 CLINTON St.	
3. NAME OF DECEASED (Type or print) ANNA First JONES Middle JONES Last		4. DATE OF DEATH Month JUNE Day 13 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ??		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (City and state or country) MISSOURI
13. FATHER'S NAME LOREN DEAN		14. MOTHER'S MAIDEN NAME JANE ?	
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. UNKNOWN	17. INFORMANT ST. LOUIS CITY HOSPITAL RECORD. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia due to cerebral arterial thrombosis. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) generalized arteriosclerosis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 33 2 x
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 6/12/56 to 6/13/56 and last saw her alive on 6/13/56 Death occurred at 11:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert M. Denton MD (Degree or title)		22b. ADDRESS 1515 LAFAYETTE A.E.	22c. DATE SIGNED 6/14/56
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 6-30-56	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Rowland Aker Mortuary Service ADDRESS 1114 Northchapel Ave. St. Louis 10, Mo.		25. DATE RECD. BY LOCAL REG. JUN 27 1956	26. REGISTRAR'S SIGNATURE Carl Smith MD m & B

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.....

Licensed Embalmer No.....

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.