

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28630

FILED SEP 6 1956

Registration District No. 318 Primary Registration District 1003 Registrar's No. 7541

300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1. | | Length of stay in lb 2 Wks. | d. STREET ADDRESS (If outside, give location) 3507 Norwood | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First LILLIAN Middle M. Last JONES | | | 4. DATE OF DEATH Month AUGUST Day 12 Year 1956 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-8-1881 | 9. AGE (In years last birthday) 75 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Elias Diamond | | | 14. MOTHER'S MAIDEN NAME Carrie Stenberg | | |
| 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 Address Clifford Jones, 3507 Norwood | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infection DUE TO (b) Generalized Carcinomatosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 199-9 | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 mos |
| 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 _____ 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 7/29/56 to 8/12/56 and last saw her alive on 8/12/56 Death occurred at 6:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) J. Earl Smith, M.D. | | | 22b. ADDRESS 1515 LAFAYETTE AVE. | | 22c. DATE SIGNED 8/13/56. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE 8-15-1956 | 23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory | | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri |
| 24. FUNERAL DIRECTOR ADDRESS McLaughlin's, 2301 Lafayette | | 25. DATE REC'D. BY LOCAL REG. AUG 14 1956 | | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. <i>S.P.</i> | |

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

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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 *James R. Chapman*

Licensed Embalmer No. 427

P. O. Address *St. Louis*

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.