

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43277

FILED DEC 27 1956

Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **11250**

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 Mo		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4103 SHAW		Length of stay in 1b 2 1/2 STREET ADDRESS (If outside, give location) 4103 SHAW	
3. NAME OF DECEASED (Type or print) JUDITH ANN JONES		4. DATE OF DEATH DEC. 6 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 30 1943
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL GIRL		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 13
13. FATHER'S NAME THOMAS JONES		11. BIRTHPLACE (City and state or country) Mo.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. NONE		14. MOTHER'S MAIDEN NAME DOROTHY WATSON	
17. INFORMANT THOMAS JONES		Address 4103 SHAW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor (Carcinoma)			INTERVAL BETWEEN ONSET AND DEATH 6 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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		20g. COUNTY STATE	
21. I attended the deceased from June 1, 1956 to 12/6/56 and last saw her alive on 12/5/56 Death occurred at 7:45 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. J. Ryan		22b. ADDRESS 2602 S Grand Bl	
22c. DATE SIGNED 12/8/56			
23a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL		23b. DATE DEC. 10 1956	
23c. NAME OF CEMETERY OR CREMATORY MT. Hope CEM.		23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo	
24. FUNERAL DIRECTOR Thomas Kates 2906 Gravois		25. DATE RECD. BY LOCAL REG. DEC 10 1956	
26. REGISTRAR'S SIGNATURE J. Carl Smith Mo			

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Leo J. Budd

Licensed Embalmer No.....
3

P. O. Address.....
St. Louis

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.