

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6335

FILED FEB 25 1957.

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1210

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Illinois</u> b. COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>St. Louis</u>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <u>Sparta</u>   |  | <u>8120</u><br>8<br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <u>Ma Pacific Hosp</u>  |                                  | Length of stay in lb<br><u>25 hrs.</u>  | 31 STREET<br>ADDRESS (If outside, give location)  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                    |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>John</u> Middle <u>ALLEN</u> Last <u>JONES</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>FEB</u> Day <u>3</u> Year <u>1957</u>  |  |   |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>FEB 7-1889</u>   | 9. AGE (In years last birthday)<br><u>67</u>                     | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bridge Foreman</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>GMO RR</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Hot Springs, Ark.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |
| 13. FATHER'S NAME<br><u>James Jones</u>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Taulua Hampton</u>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>718-07-7355</u>   |   | 17. INFORMANT<br>Address<br><u>Mrs. John Jones, Sparta, Ill.</u> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>? Acute hemorrhagic pancreatitis -</u><br><u>fulminating</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>587.0</u> |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>   |
| 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.)<br><u>587.0</u>  |   |  |   |
| 20c. TIME OF INJURY<br>Hour <u>7:40 PM</u> Month <u>1-4-57</u> Day <u>7</u> Year <u>1957</u><br>a. m. p. m.   |                                  | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><u>Ma Pacific Hospital</u>                                     |   |  |   |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20f. CITY, TOWN, OR LOCATION  |   | 20g. COUNTY STATE  |   |
| 21. I attended the deceased from <u>1-4-57</u> to <u>2-3-57</u> and last saw <u>him</u> alive on <u>2-3-57</u> .<br>Death occurred at <u>7:40 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |   |  |   |
| 22a. SIGNATURE<br><u>Borom Passanante M.D.</u> (Degree or title)  |                                  |   | 22b. ADDRESS<br><u>Ma Pacific Hospital</u>  |  | 22c. DATE SIGNED<br><u>2-5-57</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>removal</u>   |                                  | 23b. DATE<br><u>2-5-57</u>  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)<br><u>Sparta, Ill.</u>                          |
| 24. FUNERAL DIRECTOR<br><u>Walker-Paul, Sparta, Ill.</u>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><u>FEB 6 '57</u>  |   | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith M.D.</u>              |   |

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 embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Harvey Kahle*

Licensed Embalmer No. 45

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.