Health, Welfare Public Service

. 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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 14876 4159

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

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital give street address) HOSPITAL OR INSTITUTION BARNES HOSPITAL Length of stay in 1b
04

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ill. b. COUNTY St. Clair
c. CITY OR TOWN E. St. Louis Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 4122 R. Tudor (If outside, give location) Reside on Farm Yes ☐ No ☒
32

3. NAME OF DECEASED (Type or print) First ROBERT Middle N. Last JONES
4. DATE OF DEATH Month APRIL Day 29, Year 1957
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-8-35
9. AGE (In years last birthday) 21
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY unemployed
11. BIRTHPLACE (City and state or country) Noxubee Miss
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Napoleon Jones
14. MOTHER'S MAIDEN NAME Annie Mae Haynes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Napoleon Jones Address 4122 R. Tudor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sickle Cell Anemia — INTERVAL BETWEEN ONSET AND DEATH 21 Yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 292.6
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Inter -Ventricular Defect
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 APRIL 27, 1957 to APRIL 29, 1957 and last saw her/him alive on APR. 29, 1957
Death occurred at 12:50 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. Vemillion, M.D. (Degree or title) M.D
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 4/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 5-1-57
23c. NAME OF CEMETERY OR CREMATORY Bocker Washington
23d. LOCATION (City, town, or county) (State) E. St. Louis, Ill.

24. FUNERAL DIRECTOR C.T. Nash Funeral Home ADDRESS 1114 N. 13 St.
25. DATE RECD. BY LOCAL REG. MAY 1 '57
26. REGISTRAR'S SIGNATURE J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed M. Frances Nas

Licensed Embalmer No. 44

P. O. Address 3847 O

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