FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33703

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7787

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes # No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Lutheran Hospital — Length of stay in Ib: 2 hours

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY: St. Louis
c. CITY OR TOWN: Spanish Lake — Inside Limits Yes # No ☐
STREET ADDRESS (If outside, give location): 1016 Prigge Road — Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print): First THOMAS Middle L. Last JONES
4. DATE OF DEATH: Month August Day 19 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED # NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 7, 1893
9. AGE (In years last birthday): 63 — 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): Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY: Chapmann Clyg.CO.
11. BIRTHPLACE (City and state or country): St. Louis, MO
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James W. Jones
14. MOTHER'S MAIDEN NAME: Florence A. Draper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 486-14-7657
17. INFORMANT: Mrs. Anna Jones — Address: 1016 Prigge Road, (L 15) MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Complete Anterior Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteria Scleroses
DUE TO (c) 420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. Myocarditis
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 3/20/52 to 8/19/57 and last saw her/him alive on 8/19/57
Death occurred at 11:30 am m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Walter H. Hoch MD (Degree or title)
22b. ADDRESS: 3108 S. Grand
22c. DATE SIGNED: AUG 20 '57
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8-22-57
23c. NAME OF CEMETERY OR CREMATORY: Friedens Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, MO
24. FUNERAL DIRECTOR: SUEDMEYER & SON'S — ADDRESS: 3934 N. 20th Street
25. DATE RECD. BY LOCAL REG.: AUG 20 '57
26. REGISTRAR'S SIGNATURE: J. Earl Smith, MD S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due

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 Coron E. Percy

Licensed Embalmer No. 4

P. O. Address St. Lo

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.