

FILED DEC 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45977
STATE FILE NUMBER
11633

Registration District No. 318 Primary Registration District No. 1003 Registrar No. 11633

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 27 Homer G. Phillips Hos.		Length of stay in lb 26 STREET ADDRESS. I639 A. Arlington (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Basil Jones			4. DATE OF DEATH Month Day Year Nov, 30, 1957
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr, 22, 1914
9. AGE (In years last birthday) 43		10. KIND OF BUSINESS OR INDUSTRY Wab. R.R.	11. BIRTHPLACE (City and state or country) Amory, Miss.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lalorer		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Green Jones		14. MOTHER'S MAIDEN NAME Maggie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 425-10-8485	17. INFORMANT Margaret Jones I639 A. Arlington Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute gastro intestinal hemorrhage</i> DUE TO (b) <i>contributory: - Biliary Cirrhosis</i> DUE TO (c) <i>with portal Hypertension</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 581-0	
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 COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 9:25 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>James M. Kelly</i> (Deputy) (Title)		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 12-3-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/6/57	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR Wright Funeral Home 3100 Easton Ave.		25. DATE RECD. BY LOCAL REG. DEC 4 '57	
26. REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i> M. J. B.			

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 *Arthur L. Hilliard*

Licensed Embalmer No. 420

P. O. Address 3100 E. 00

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.