

Health,
& Welfare
Public
Service

S. 300
v. 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 DEC 30 1957

STANDARD CERTIFICATE OF DEATH

46190
STATE FILE NUMBER
12120
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 38 Enroute Homer G. Phillips			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 1217 ADDRESS 2620 Franklin Avenue		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John James Henry Jones Parker				4. DATE OF DEATH Month 12 Day 12 Year 57	5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1907	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months 7 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Albert Jones				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. ?		17. INFORMANT Lillian Mae Jones Parker		Address 2620 A. Franklin					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis 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) 500*								INTERVAL BETWEEN ONSET AND DEATH Dec 1-57			
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 _____ 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 Dec 1-57 to Dec 12 and last saw her alive on Dec 12-57 Death occurred at 2:45 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.											
22. SIGNATURE (Degree or title) James M. D. W. D.				22b. ADDRESS 2621 1/2 Franklin		22c. DATE SIGNED 12-19-57					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-19-57		23c. NAME OF CEMETERY OR CREMATORY National		23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri					
24. FUNERAL DIRECTOR Ellis Funeral Home		ADDRESS 2820 Stoddard St.		25. DATE RECD. BY LOCAL REG. DEC 17 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith MD					

MFB

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MAY 29 1958

OFFICE OF THE STATE BOARD OF HEALTH

MAY 28 1958

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 E. Culkin*

Licensed Embalmer No. *412*

P. O. Address *Albany*

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.

78-11-31