

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32294-57 58-019368  
STATE FILE NUMBER

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 130

FILED MAY 26 1958

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. CHARLES</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPHS HOSP</u> Length of stay in lb <u>1 HR.</u>		d. STREET ADDRESS (If outside, give location) <u>1145 SPRING</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DIANNE</u> Middle <u>JONES</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1958</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>ST. CHARLES Mo.</u>
13. FATHER'S NAME <u>MARVIN H. JONES</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE B. POTEET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MARVIN H. JONES, ST. CHARLES Mo.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute meningitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
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)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 _____ Month _____ Day _____ 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 <u>August 1957</u> , to <u>May 16, 1958</u> and last saw her alive on <u>May 16, 1958</u> Death occurred at <u>8:25 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Don Z. Randall M.D.</u>		22b. ADDRESS <u>207 N. 5th St. Charles Mo.</u>	22c. DATE SIGNED <u>May 16 1958</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-17-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEM.</u>	23d. LOCATION (City, town, or county) <u>ST. CHARLES Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>P. L. Prinster, St. Charles Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 18-58</u>	26. REGISTRAR'S SIGNATURE <u>Margaret Wilson</u>

MAY 26 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

*Body not embalmed*

Signed.....  
*C. L. Prinsted*

Licensed Embalmer No.....

P. O. Address .....

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.