

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023436

STATE FILE NUMBER

6574

FILED JUL 14 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

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

1. PLACE OF DEATH a. COUNTY <i>St Louis Mo.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Franklin</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis Mo</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St Clair Mo.</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Deaconess Hosp</i> Length of stay in lb <i>1 week</i>		d. STREET ADDRESS (If outside, give location) <i>31</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Garnett</i> Middle <i>A</i> Last <i>Jones</i>		4. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 11 1867</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Doctor</i>		100. KIND OF BUSINESS OR INDUSTRY <i>retired</i>	11. BIRTHPLACE (City and state or country) <i>St Louis Mo</i>
13. FATHER'S NAME <i>Isaac H Jones</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Mc Leadd</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>none none</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mrs. Alfred C. Palle</i> Address <i>1320 McCarland St. St. Louis 17</i>
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>Hypostatic pneumonia</i> <i>Out of chain</i> <i>Fracture neck of femur</i> Conditions, if any, which gave rise to (b) <i>Senility & arteriosclerosis</i> IMMEDIATE CAUSE (b) <i>Senility & arteriosclerosis</i> IMMEDIATE CAUSE (c) <i>Senility & arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility & arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>6-22-58</i>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>E902.7-45</i> <i>Fell out of chair</i>	
20c. TIME OF INJURY Hour <i>6</i> Month <i>6</i> Day <i>22</i> Year <i>58</i> a. m. <i>10</i> p. m.		20f. CITY, TOWN, OR LOCATION <i>126</i> COUNTY <i>Maplewood, Mo.</i> STATE <i>Mo.</i>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, etc.) <i>Maplewood Nursing Home</i>	
21. I attended the deceased from <i>5-20-58</i> to <i>6-30-58</i> and last saw her alive on <i>6-30-58</i> Death occurred at <i>6:10 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. A. Stirling M.D.</i> (Do not or title)		22b. ADDRESS <i>Maplewood Mo.</i>	22c. DATE SIGNED <i>7-1-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>July 3, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bellefontaine Cem</i>	23d. LOCATION (City, town, or county) (State) <i>St Louis Mo.</i>
24. FUNERAL DIRECTOR <i>Shemuel W. Kitchell</i> ADDRESS <i>St. Clair Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>JUL 1 '58</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>

(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 embalmed by me, or by Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Sherwood A. Kitchell*

Licensed Embalmer No. *38*

P. O. Address *St. Clair*

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.