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v. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-023439
STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6371

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS — Inside Limits Yes ☐ No ☐

c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 01 2706 STOddARd — Length of stay in 1b

d. STREET ADDRESS (If outside, give location) 02190 2706 STOddARd ST — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First SYLVESTER Middle Last JONES

4. DATE OF DEATH Month 6 Day 21 Year 58

5. SEX MALE 2

6. COLOR OR RACE Colored

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ 1 DIVORCED ☐

8. DATE OF BIRTH APRIL 8 1919

9. AGE (In years last birthday) 39 YRS — IF UNDER 1 YEAR Months 2 Days 13 — 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 CLOTH FACTORY

11. BIRTHPLACE (City and state or country) GRENADA, MISS 1

12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME ISAREAL JONES

13b. MOTHER'S MAIDEN NAME CORA LUCAS

14. NAME OF HUSBAND OR WIFE MABEL JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WORLD WAR 2

16. SOCIAL SECURITY NO.

17. INFORMANT MABEL JONES Address 2707 STOddARd ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Coronary Arteriosclerosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

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)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐ 1

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 _____, to _____ and last saw her/him alive on _____
Death occurred at 825 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M Quinn 3/Dep Dep Dep

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 6/23/58

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE 6-27-58

23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY

23d. LOCATION (City, town, or county) JEFFERSON BARRACKS (State) MO

24. FUNERAL DIRECTOR A.F. WALTON ADDRESS 2707 STOddARd

25. DATE RECD. BY LOCAL REG. JUN 24 '58

26. REGISTRAR'S SIGNATURE Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.