

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027104

STATE FILE NUMBER

7529

|   |  |   |  |   |
|---|--|---|--|---|
| FILED AUG 11 1958   |  | Registration District No. <b>318</b>  | Primary Registration District No. <b>1003</b>                            | Registrar's No. <b>1003</b>   |
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>St. Louis</b>   |   |
| Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | d. STREET ADDRESS <b>2209 2710 Madison</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>2710 Madison</b>  |  | Length of stay in lb  |  | d. STREET ADDRESS <b>2710 Madison</b>   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Christopher Columbus Jones</b>   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>July 30, 1958</b>               |   |
| 5. SEX<br><b>Male 2</b>   | 6. COLOR OR RACE<br><b>Negro</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 12, 1881</b>                                | 9. AGE (In years at birthday) <b>76</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Sardis, Mississippi</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |
| 13a. FATHER'S NAME<br><b>Warren Jones</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Anna Henderson</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Virginia Jones</b>  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>495-14-5326</b>   | 17. INFORMANT<br>Address<br><b>Virginia Jones 2710 Madison</b>           |   |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Perforated &amp; Indurated Ulcer</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   |  | <b>177X</b>   |
| 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?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Hour Month, Day, Year<br>a.m.<br>p.m.  |  |   |  |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <b>7/16/58</b> to <b>7/30/58</b> and last saw him alive on <b>7/20/58</b>  |  | Death occurred at <b>7:20 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.                                       |  |   |
| 22a. SIGNATURE<br>(Degree or title)<br><b>Douglas S. Regue M.D.</b>   |  | 22b. ADDRESS<br><b>3146 Alameda</b>   |  | 22c. DATE SIGNED<br><b>7/31/58</b><br>(State)   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><b>8/4/58</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park</b>  | 23d. LOCATION (City, town, or county)<br><b>Berkley, Missouri</b>        |   |
| 24. FUNERAL DIRECTOR<br><b>E. B. France</b>   |  | ADDRESS<br><b>1221 N. Grand</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>AUG 2 '58</b>                         | 26. REGISTRAR'S SIGNATURE<br><b>J. Carl Smith M.D.</b><br>S.P.                                    |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 William Blackman  
Licensed Embalmer No. 3467  
P. O. Address 1221 N. 2nd

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.