

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030589

STATE FILE NUMBER

8058

318

1003

FILED AUG 28 1958

Registration District No.

Primary Registration District No.

Registrar's No.

5. 300
1-57
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3635 Page	
3. NAME OF DECEASED (Type or print) First James Middle Last Jones		4. DATE OF DEATH Month 8 Day 15 Year 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 18, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI
13a. FATHER'S NAME HENRY JONES		13b. MOTHER'S MAIDEN NAME SYNTHIA VICTORIA	14. NAME OF HUSBAND OR WIFE MARY JONES (Dec.)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 500-26-2721	17. INFORMANT Mrs. Jellie Jones 3635^a Page Blvd
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Asystolia			INTERVAL BETWEEN ONSET AND DEATH undet.
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.) 331x	
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 8-14-58 2:40P to 8-15-58 4:45P and last saw him alive on 8-15-58 Death occurred at 4:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. A. Inman (Degree or title)		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 8-18-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 8-21-58	
23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM.		23d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO	
24. FUNERAL DIRECTOR A.F. WALTON 2707 STODDARD		25. DATE RECD. BY LOCAL REG. AUG 19 58	
		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

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 P. Herliard

Licensed Embalmer No. *4221*.....

P. O. Address *3100 Easton A*

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.