

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034385

STATE FILE NUMBER

FILED OCT 3 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9311

300
1-57

1. PLACE OF DEATH a. COUNTY <u>None</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</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. Louis Chronic</u>		Length of stay in lb <u>3 mo. 2/79</u>	d. STREET ADDRESS (If outside, give location) <u>1902 Thurman</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elzie</u> Middle <u>E</u> East <u>Jones</u>			4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1958</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5 1875</u>	9. AGE (In years) <u>82</u> <small>(Last Birth Day)</small>	IF UNDER 1 YEAR Months <u>8</u> Days <u>26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Light Hauling</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Truck</u>	11. BIRTHPLACE (City and state or country) <u>Tenn Union City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>XXXX Jim Jones</u>		13b. MOTHER'S MAIDEN NAME <u>XXXX Mildred Harpole</u>		14. NAME OF HUSBAND OR WIFE <u>Rebecca Hale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>490-14-9712</u>	17. INFORMANT Address <u>Hospital Record, 5800 Arsenal</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>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (b) <u>Arteriosclerotic Heart Disease</u> <u>3 mo.</u>	
				DUE TO (c) <u>Generalized Arteriosclerosis</u> <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</u>				19. WAS AUTOPSY PERFORMED? 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 Hour <u>12:00</u> a.m. Month, Day, Year 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>6/16/58</u> to <u>9/26/58</u> and last saw him alive on <u>9/26/58</u> Death occurred at <u>12:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u>			22b. ADDRESS <u>5800 Arsenal</u>		22c. DATE SIGNED <u>9/26/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Sep 29 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Cty Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>E.J. Schnur 3125 Lafayette</u>			25. DATE RECD. BY LOCAL REG. <u>SEP 29 58</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Thomas R. Fenwick*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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.