

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037905  
STATE FILE NUMBER

FILED OCT 17 1958 Registration District No. 316 Primary Registration District No. 1003 Registrar's No. 9701

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN ST. Louis                       |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN St. Louis<br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 48 Community Hospital |  | Length of stay in 1b<br>7/17   | d. STREET ADDRESS (If outside, give location)<br>4005a. Cook<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |                          |   |  |                                       |   |
|--|--------------------------|---|--|---------------------------------------|---|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Issac Wm. Jones  |                          |   | 4. DATE OF DEATH<br>Month Day Year<br>10 8 58.                       |                                       |   |
| 5. SEX<br>Male 2   | 6. COLOR OR RACE<br>Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>5/21/1904  | 9. AGE (In years last birthday)<br>54 | IF UNDER 1 YEAR<br>Months Days Hours Min.<br>5 11 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer             |                          | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   | 11. BIRTHPLACE (City and state or country)<br>Indianapolis Indiana / |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>USA               |
| 13. FATHER'S NAME<br>Henry Jones   |                          |   | 14. MOTHER'S MAIDEN NAME<br>May Johnson                              |                                       |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No |                          | 16. SOCIAL SECURITY NO.<br>488-01-3215  | 17. INFORMANT<br>Henry Jones 2337a Pine St.                          |                                       |   |

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|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction         |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>6 wks  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) = Atherosclerosis, Hypertension<br>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?<br>YES <input checked="" type="checkbox"/> NO <input 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. 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 Oct. 2 to Oct 8 and last saw her alive on Oct 8 '58  
Death occurred at 7:30 a m on the date stated above; and to the best of my knowledge, from the causes stated.

|  |                       |   |  |
|--|-----------------------|---|--|
| 22a. SIGNATURE<br>Walter A. Younge MD                | (Degree or title)     | 22b. ADDRESS<br>2337 Market St                        | 22c. DATE SIGNED<br>10-9-58                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal | 23b. DATE<br>10/13/58 | 23c. NAME OF CEMETERY OR CREMATORY<br>Washington Park | 23d. LOCATION (City, town, or county) (State)<br>County MO |

|   |                            |  |  |
|---|----------------------------|--|--|
| 24. FUNERAL DIRECTOR<br>Herman J. Smith | ADDRESS<br>4247 W. Labadie | 25. DATE RECD. BY LOCAL REG.<br>OCT 10 '58 | 26. REGISTRAR'S SIGNATURE<br>Earl Smith MD |
|---|----------------------------|--|--|

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service  
300 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. 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

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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 *H. Claude Gordon*

Licensed Embalmer No. *34*

P. O. Address *4575 00*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.