

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037908

STATE FILE NUMBER

FILED OCT 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9948

300
-57

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, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If outside, give location) 5308 Harney Ave.	
3. NAME OF DECEASED (Type or print) First LAURA Middle FRANCES Last JONES		4. DATE OF DEATH Month October Day 16 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales person		10b. KIND OF BUSINESS OR INDUSTRY Lickhalter Bakery	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME John W. Peckington		13b. MOTHER'S MAIDEN NAME Mathilda Ann Snavelly	14. NAME OF HUSBAND OR WIFE -
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. 495-28-1945	17. INFORMANT Address Mrs. Gustave Rischer 5311 Ruskin Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute urinary tract infection Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic debilitation DUE TO (c) Multiple strokes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 334x			INTERVAL BETWEEN ONSET AND DEATH
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 _____ 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 10-6-58 to 10-16-58 and last saw her alive on 10-16-58 Death occurred at 4:20 P. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lilay L. Ghent		22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 10-17-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-20-58	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS Calvin F. Feutz 4828 Natural Bridge		25. DATE RECD. BY LOCAL REG. OCT 17 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith MO

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 Ralph L. Linderus

Licensed Embalmer No. 4275

P. O. Address St. Louis, Mo

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.