

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041214

STATE FILE NUMBER

FILED NOV 18 1958 Registration District No. 316 Primary Registration District No. 6076 Registrar's No. 410

300
-57

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Carter	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Farmington - Rural		c. CITY OR TOWN Elsinore Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital # 4		Length of stay in lb 44Y, 6M, 6Days STREET ADDRESS 0180 - (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAMIE Middle JONES Last JONES			4. DATE OF DEATH Month October Day 28 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? , About 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housemaid		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. abt. 70 Last birthday Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME G. R. Jones		13b. MOTHER'S MAIDEN NAME Mary F. Morgan	14. NAME OF HUSBAND OR WIFE none
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. none	17. INFORMANT Address Records, State Hospital # 4, Farmington, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pulmonary tuberculosis - - - - - revealed by Interval between ONSET AND DEATH x-ray, May 1958. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Dementia Praecox Psychosis - - - - - Abt. 55 yrs.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 _____ Month, Day, Year _____ 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. 8, 1958 to Oct. 28, 1958 and last saw her alive on Oct. 28, 1958 Death occurred at 6:00 A. M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John A. Brennan, M.D.</i>		22b. ADDRESS State Hospital No. 4 Farmington, Missouri	22c. DATE SIGNED 10-28-58.
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 28, 1958	23c. NAME OF CEMETERY OR CREMATORY Washington Univ. Anat. Dept.	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS Via Ocean Funeral Home, Farmington, Mo.		25. DATE RECD. BY LOCAL REG. Nov. 12, 1958	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>

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 *Washington U School of Medicine per M. Hoa*
Licensed Embalmer No.
P. O. Address

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.