

HEALTH, WELFARE & PUBLIC SERVICE  
STANDARD CERTIFICATE OF DEATH

58-046698  
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3023

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                                  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b><br>Length of stay in lb <b>15 days</b>  |                                  | d. STREET ADDRESS (If outside, give location) <b>1239 Amherst Place</b><br>Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>TERRACE LOURN JONES</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>November 18, 1958</b>                |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Jan 29, 1898</b>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Car Parts Inc.</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Montgomery Co, Missouri</b>  |
| 13. FATHER'S NAME<br><b>Milton E. Jones</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Gray</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no none</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>489-03-6582</b>   | 17. INFORMANT Address<br><b>Mrs. Louella Jones, 1239 Amherst Place.</b>       |
| 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) <b>Malignant hypertension</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Terminal bronchopneumonia</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs.</b>                             |
| 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<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 <b>Aug 1952</b> to <b>Nov. 18, 1958</b> and last saw <sup>her</sup> him alive on <b>Nov. 18, 1958</b><br>Death occurred at <b>3:20 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>J. J. Macdonald, M.D.</b>  |                                  | 22b. ADDRESS<br><b>4161 Lindeell Blvd</b>   | 22c. DATE SIGNED<br><b>11-20-58</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>Nov 21, 1958</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill Gardens</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b> |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Shepard Funeral Home 1167 Hamilton Ave</b>   |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>11-20-58</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Herbert R. Clonka, M.D./J.P.</b>              |

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All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Stanley H. Simpson*.....

Licensed Embalmer No. *H-1*.....

P. O. Address *H. R.*.....

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.