Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003129
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2947

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS HOSPITAL #1 — Length of stay in 1b	d. STREET ADDRESS 1723 Lovejoy (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CHARITY	COLLINS	JONES	1	26	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	Col.		9-28-84	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	Starkville, Miss.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Jim Collins	Annie Jerome	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			Mrs. Henderson	1723 Lovejoy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Diabetes Mellitus — unk.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 260+

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerosis obliterans of lower extremities with gangrene of left great toe.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1-15-1959, to 1-26-1959 and last saw her/him alive on 1/26/59

Death occurred at 6:05 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jean C. Chapman MD (Degree or title) — 22b. ADDRESS 1515 LAFAYETTE AVE — 22c. DATE SIGNED 1/26/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 23b. DATE 2-1-59 — 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery — 23d. LOCATION (City, town, or county) St. Louis, (State) Mo.

24. FUNERAL DIRECTOR A.L. Beal Und. Co. — ADDRESS 4303 Delmar — 25. DATE RECD. BY LOCAL REG. JAN 27 '59 — 26. REGISTRAR'S SIGNATURE Carl Smith MD MPH

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed .....
Signature of Student Embalmer

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.