

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003132  
STATE FILE NUMBER

FILED FEB 10 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **1048**

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-57  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Length of stay in lb <b>1 mo.</b>	d. STREET ADDRESS (If outside, give location) <b>2199 4497 Forest Park Blvd.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Greeley</b> Last <b>Jones</b>			4. DATE OF DEATH Month <b>1</b> Day <b>28</b> Year <b>59</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-15-1872</b>	9. AGE (In years, months, days) <b>86</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Prop.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	11. BIRTHPLACE (City and state or country) <b>Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Jones</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Walker</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>UNK</b>	17. INFORMANT <b>Nora Selpins 6338 Veto Altoona Mo.</b> Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>stab</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b> <b>1 mo.</b>	
	DUE TO (c) <b>Generalized Arteriosclerosis</b> <b>1 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>		19. WAS AUTOPSY PERFORMED? 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 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 <b>12-22-58</b> to <b>1-28-59</b> and last saw her alive on <b>1-28-59</b> Death occurred at <b>9:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>	22b. ADDRESS <b>5800 Arsenal</b>	22c. DATE SIGNED <b>1/29/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-31-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Cedar Grove Ill</b>
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24. FUNERAL DIRECTOR <b>Beckham Bros 6409 Grand</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JAN 29 59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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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 *Ken M. Sezenure* .....

Licensed Embalmer No. *4343* .....  
P. O. Address *St. Lucia 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.