THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003134 STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1013

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 2338 Lucas — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo
b. COUNTY
c. CITY OR TOWN St Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 2338 Lucas (If outside, give location) — Residence on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Robert Middle Carter Last Jones
4. DATE OF DEATH: Month 1 Day 12 Year 19
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1955
9. AGE (In years last birthday) 3 — IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (City or town, state or country) Mo
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unk
14. MOTHER'S MAIDEN NAME Unk
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give year or dates of service)
16. SOCIAL SECURITY NO. Unk
17. INFORMANT R. Taylor Address 1300 Clark

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) Suffocation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) When deceased was found
DUE TO (c) in bed at home on

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Jan-12-1959 Eq. 4.018

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.) Suffocation from
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year Unk / 12 found in bed at home
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, office, other bldg., etc.) home
20f. CITY, TOWN, OR LOCATION St Louis COUNTY STATE Mo

21. I attended the deceased from Mo to ..... and last saw her/him alive on ..... Death occurred at home m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jerry M Quinn Coroner — 22b. ADDRESS 1300 Clark — 22c. DATE SIGNED 1/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify) — 23b. DATE 1-31-59 — 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board — 23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR Rowland-Aker Mortuary Service ADDRESS 4104 Manchester Ave. St. Louis 10, Mo. (Licensed Embalmer's Statement on Reverse Side)

25. DATE RECD. BY LOCAL REG. JAN 29 '59

26. REGISTRAR'S SIGNATURE Karl Smith MD MDB

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.