

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003135
STATE FILE NUMBER

510

FILED JAN 28 1959 Registration District No. Primary Registration District No. Registrar 2

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residency before admission) a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Length of stay in lb 13 yrs. 1 mo.		d. STREET ADDRESS 5800 Arsenal St.	
3. NAME OF DECEASED (Type or print) First Middle Last William J. Jones			4. DATE OF DEATH Month Day Year 1-14-59		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1874	9. AGE (In years at birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Henry Jones		13b. MOTHER'S MAIDEN NAME Josephine Hancock	
14. NAME OF HUSBAND OR WIFE --		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. ---	
17. INFORMANT St. Louis Chronic Hospital Records		Address 5800 Arsenal, St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Lateral Lobar Pneumonia	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) 490X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis - 13 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 Days.	
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 8-30-45, to 1-14-59 and last saw her alive on 1-14-59		Death occurred at 6:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John W. Beckham, M.D.		22b. ADDRESS 5800 Arsenal		22c. DATE SIGNED 1/14/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-15-59		23c. NAME OF CEMETERY OR CREMATORY Washington, D.C.	
24. FUNERAL DIRECTOR Albert H. Hoppe		ADDRESS 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. JAN 15 '59	
				26. REGISTRAR'S SIGNATURE Earl Smith M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

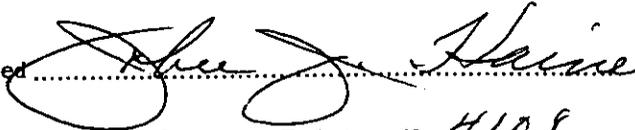
MEDICAL CERTIFICATION

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 
Licensed Embalmer No. 4108
P. O. Address St. Louis, 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.**