Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-003137

FILED JAN 28 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 418

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 3035 Cass Ave — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3035 Cass Avenue — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Lonnie Middle: Last: Joyner

4. DATE OF DEATH: Month: Jan. Day: 8 Year: 1959

5. SEX: Male 2
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF DATH: Mar. 4, 1901
9. AGE (In years last birthday): 57 — 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): Farm & Home Loan Co.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Arkansas
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: Calvin Joyner
13b. MOTHER'S MAIDEN NAME: Sarah Carr
14. NAME OF HUSBAND OR WIFE: Floy Joyner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 492-07-8168
17. INFORMANT: Floy Joyner Address: 3035 Cass Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Thrombosis
DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH: about 2 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): nothing - 332x
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 Jan. 6-59, to Jan. 8 59 and last saw him alive on 1-8-59
Death occurred at 1:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] M.D. (Degree or title)
22b. ADDRESS: 4 a South Compton Avenue
22c. DATE SIGNED: JAN 13 '59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan. 13, 1959
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Mc Ghee, Arkansas

24. FUNERAL DIRECTOR: E. B. Koonce ADDRESS: 1221 N. Grand Ave
25. DATE RECD. BY LOCAL REG.: JAN 13 '59
26. REGISTRAR'S SIGNATURE: Earl Smith MD

(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 .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 4755

P. O. Address 122 N. Gra

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.