

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011070

State File No.

2 1970

Registrar's No.

FILED MAR 17 1959

REG. DIST. NO.

PRIMARY REG. DIST. NO.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Home of Mo. Hospital		d. STREET ADDRESS (If rural, give location) 5351 Delmar	
3. NAME OF DECEASED (Type or Print) a. (First) Tillie b. (Middle) Spann c. (Last) Jones		4. DATE OF DEATH (Month) (Day) (Year) Feb. 22 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 18, 1870
9. AGE (In years last birthday) 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Venice, Illinois
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Spann	
13b. MOTHER'S MAIDEN NAME Julia Kull		14. NAME OF HUSBAND OR WIFE William Porter Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Lewis C. Robertson, Sup't.		ADDRESS Masonic Home of Missouri	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL EXAMINATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 420.1 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
19b. MAJOR FINDINGS OF OPERATION		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/19/59, 19__, to 3/22/59, 19__, that I last saw the deceased alive on 2/21/59, 19__, and that death occurred at 2:20 A.M., from the causes and on the date stated above.			
23a. SIGNATURE Harold E. Walters M.D.		23b. ADDRESS 3720 Washington St. Louis, Mo.	
23c. DATE SIGNED 2-22-59		24a. BURNIAL CREMATION, REMOVAL (Specify) Removal	
24b. DATE 2/25/59		24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
24d. LOCATION (City, town, or county) (State) Kirkwood, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Pitzinger Mortuary, Kirkwood, Mo.	
DATE REC'D BY LOCAL REG. FEB 25 59		REGISTRAR'S SIGNATURE Roan Smith, M.D.	

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
Student Embalmer

Signed

Ben C. Hoffman

Licensed Embalmer No. *4366*

P. O. Address *Houston, 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 this body is not embalmed, fact should be so stated above.