

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011071  
STATE FILE NUMBER

300  
-57  
10  
P

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL DISEASES IN PART I MUST BE CAUSALLY RELATED.

Doctor, coroner, etc. must use only standard nomenclature in referring to cause of death.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-2545**

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY _____  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>                |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |                                  | c. CITY OR TOWN <b>Pine Lawn 4301</b>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>DePaul Hospt</b>  |                                  | d. STREET ADDRESS (If outside, give location)<br><b>2305 Kienlen Ave.</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>William</b> Middle <b>F</b> Last <b>Jones</b>  |                                  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>11</b> Year <b>59</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-11-1874</b>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Iron Worker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Const.</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Missouri</b>           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  | 13a. FATHER'S NAME<br><b>Richard Jones</b>  |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Unk.</b>  |                                  | 14. NAME OF HUSBAND OR WIFE<br><b>Theresa Jones</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk.</b>  | 17. INFORMANT<br><b>Theresa Jones</b> Address <b>2305R Kienlen Ave.</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis cerebral</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>330x</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>?</b>           |
| 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<br>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>3-11-59</b> to <b>3-11-59</b> and last saw him alive on <b>3-9-59</b><br>Death occurred at <b>10:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Chas. Goad M.D.</b> (Degree or title) <b>C</b>   |                                  | 22b. ADDRESS<br><b>6000 W. Flannery</b>   |   |
| 22c. DATE SIGNED<br><b>3-12-59</b>  |                                  | 23. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>3-14-59</b>   |   |
| 23c. LOCATION (City, town, or county)<br><b>St. Louis, Missouri</b>   |                                  | 23d. DATE RECD. BY LOCAL REG.<br><b>MAR 12 '59</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>J.W. Clark F.H. 1125 Hodiament Ave.</b>  |                                  | 25. REGISTRAR'S SIGNATURE<br><b>Roan Smith, M.D.</b>  |   |

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 *Alfred J. Bodeker* .....

Licensed Embalmer No. *2663* .....

P. O. Address *1125 Horizon* .....

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.