Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019299
STATE FILE NUMBER

FILED MAY 22 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 4594

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST. LOUIS CITY HOSP. #1 — 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): 2353 Scott — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: ANN A — Middle: — Last: JONES

4. DATE OF DEATH: Month 5 — Day 7 — Year 59

5. SEX: Female **6. COLOR OR RACE**: Negro **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 18, 1886

9. AGE (In years last birthday): 72 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Middlepoint, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: George Smith
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Alfred Jones

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.: None
17. INFORMANT: Alfred Jones — Address: 2353 Scott

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): Septicemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Pyelonephritis
DUE TO (c): 600.0
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerosis Obliterans ; Uremia

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 3-25-59, to 5-7-59 and last saw her/him alive on 5-7-59
Death occurred at 4:55a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Samuel R. Joseph (Degree or title) MD
22b. ADDRESS: 1515 Layfayette Ave.
22c. DATE SIGNED: 5-7-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burail
23b. DATE: 5/13/59
23c. NAME OF CEMETERY OR CREMATORY: Oakdale Cemetery
23d. LOCATION (City, town, or county) (State): Lemay, Missouri

24. FUNERAL DIRECTOR: E. B. Kramer — ADDRESS: 1221 N. Grand Blvd.
25. DATE RECD. BY LOCAL REG.: MAY 11 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(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 Melvin Blackburn

Licensed Embalmer No. 3162

P. O. Address 1221 N. Grand

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.