

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019301

STATE FILE NUMBER  
Registration No. 4986

FILED JUN 11 1959

Registration District No. Primary Registration District No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 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. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Mo.</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>St. Louis.</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Enroute City Hospital DOA</b>   |                                  | Length of stay in lb.   | d. STREET ADDRESS (If outside, give location)<br><b>706 No. Kingshighway</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Clifford Robert Jones</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>May 20, 1959</b>   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sales Advertising, Co.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><b>72</b><br>IF UNDER 1 YEAR: Months Days Hours Min.<br>IF UNDER 24 HRS  |
| 11. BIRTHPLACE (City and state or country)<br><b>Cincinnati, Ohio.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13a. FATHER'S NAME<br><b>Robert Jones</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Catherine Walsh</b>   | 14. NAME OF HUSBAND OR WIFE<br><b>Lillian</b>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>492-16-3901</b>   | 17. INFORMANT Address<br><b>Mrs. Charlotte Niehaus, 1015 Ross.</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>Coronary Occlusion</b><br><b>Coronary Sclerosis</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (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>420-1</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 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 Month, Day, Year<br>a.m.<br>p.m.  |                                  | 20d. INJURY OCCURRED WHILE AT <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 _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |   |   |
| 22a. SIGNATURE<br><b>Paul J. Simon</b><br>(Deputy) <b>Croner</b>  |                                  | 22b. ADDRESS<br><b>1300 Clark</b>   | 22c. DATE SIGNED<br><b>5/22/59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><b>5-22-59</b>      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Valhalla Crematory</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b>   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Albert H. Hoppe 4700 Washington, Blvd.</b>   |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 22 '59</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith, M.D.</b>  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 .....  
*Lawrence G. Meyer*

Licensed Embalmer No. ....

P. O. Address .....

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.