

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019304  
STATE FILE NUMBER  
2 4577  
Registrar's No.

XC 20725730  
SL 18508

FILED MAY 22 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>ST CLAIR</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>		c. CITY OR TOWN <b>EAST ST LOUIS</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS ADMIN HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>1305 ILLINOIS AVE</b>	
Length of stay in lb <b>156 DAYS</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>A</b> Last <b>JONES</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>9</b> Year <b>1959</b>		
---	--	--	--	--	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/07</b>	9. AGE (In years at first birthday) <b>51</b>	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) <b>STEAM FITTER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	11. BIRTHPLACE (City and state or country) <b>E ST LOUIS, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	---	--

13a. FATHER'S NAME <b>SAUL JONES</b>	13b. MOTHER'S MAIDEN NAME <b>CLARA MEUCAL</b>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give year or dates of service) <b>YES WW II</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>VA HOSP RECORDS</b>	Address <b>915 N GRAND ST LOUIS MO</b>
---	-------------------------	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DIFFUSE BRONCHOPNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>EPIDERMOID CARCINOMA OF ESOPHOGUS</b>	
	DUE TO (c) <b>150 x H</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>TUBERCULOSIS LUL</b>		19. WAS AUTOPSY PERFORMED? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 Hour _____ Month, Day, Year a.m. _____ 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 <b>VAH, ST LOUIS, MO</b>	COUNTY _____ STATE _____
---	--	--	--------------------------

21. / attended the deceased from **12/4/58** to **5/9/59** and last saw him alive on **5/9/59**  
Death occurred at **2:00 PM** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>E. EGO-AQUIRRE</b>	22b. ADDRESS <b>M.D. VAH, ST LOUIS, MO</b>	22c. DATE SIGNED <b>5-9-59</b>
---	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5-12-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. CARMEL</b>	23d. LOCATION (City, town, or county) (State) <b>Belleville Ill.</b>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <b>NEW WALSH BARNES</b>	ADDRESS <b>EAST ST LOUIS ILL</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 11 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loat Smith, M.D.</b>
---	-------------------------------------	---	--

300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

MOB

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

*John Maher*

Licensed Embalmer No. 29-859

P. O. Address East St. Louis

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.