

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019985
STATE FILE NUMBER

Health JUN 2 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1408

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch, Missouri		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robt. Koch Hospital		d. STREET ADDRESS (If outside, give location) 4355 a West Bell	
3. NAME OF DECEASED (Type or print) First Middle Last Jefferson S Jaques		4. DATE OF DEATH Month Day Year May 17 1959	
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) South Carolina
13a. FATHER'S NAME Francis Jaques		13b. MOTHER'S MAIDEN NAME Lizzie Elmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Winsel Jaques 192 Smith St. Charleston S.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis			INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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 WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from 4/3/59 to 5/17/59 and last saw her/him alive on 5/17/59 Death occurred at 9:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
22a. SIGNATURE Bernard Friedman (Degree or title)		22b. ADDRESS Robt. Koch Hospital	
22c. DATE SIGNED 5/18/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-21-59	
23c. NAME OF CEMETERY OR CREMATORY Unity Cemetery		23d. LOCATION (City, town, or county) (State) Holly Hill, South Carolina	
24. FUNERAL DIRECTOR Ellis Funeral Home		25. DATE RECD. BY LOCAL REG. 5-21-59	
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Fulton E. Culb*

Licensed Embalmer No. *7198*
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.