

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 24 1959

59-026810

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-6433**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8305 POLK AVE		d. STREET ADDRESS (If outside, give location) 2403 ELLIOT	

3. NAME OF DECEASED (Type or print) First JAMES Middle CHARLES Last JONES			4. DATE OF DEATH Month July Day 4 Year 1959			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/28/52	9. AGE (last birthday) 3	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A		

13a. FATHER'S NAME J.C. WALKER		13b. MOTHER'S MAIDEN NAME MARGARET JONES		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT INEZ MCFADDEN Address 2403 ELLIOT	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) _____			
DUE TO (c) 340-3			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____		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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul Simon (Degree of) Coroner		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 7/7/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/8/59		23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON	
24. FUNERAL DIRECTOR Taylor Glenn + B. Walker		ADDRESS 4319 DELMAR		25. DATE RECD. BY LOCAL REG. JUL 8 '59	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Donald A. Jameson

Licensed Embalmer No. 5011

P. O. Address 5064 Watts St

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.