URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 8 1959

59-042035
STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210938

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 3 ½ days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Deaconess Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Pagedale (33)
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 6562 Joseph Ave.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: MR. Middle: JOHN Last: JOSEPH JOBE
4. DATE OF DEATH: Month November Day 24, Year 1959

5. SEX: M.
6. COLOR OR RACE: W.
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12/29/33
9. AGE (last birthday): 25
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Worker
10b. KIND OF BUSINESS OR INDUSTRY: Wagner Electric
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: James Elisha Jobe
13b. MOTHER'S MAIDEN NAME: Grace G. Harwell
14. NAME OF HUSBAND OR WIFE: None

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.: 487-36-8555
17. INFORMANT: James E. Jobe 6562 Joseph Ave. (Address)

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): Myocardial Infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): _____
DUE TO (c): 420.1
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)
Atypical Pneumonia

PART III. If deceased was female was there a pregnancy in last 90 days.
☐ Yes ☐ No ☐ Unknown

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 November 21, 1959 to November 24, 1959 and last saw him alive on November 24, 1959
Death occurred at 6:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert H. Ramsey, M.D. (Degree or title)
22b. ADDRESS: 25a Florissant Rd.
22c. DATE SIGNED: 11/25/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal-burial
23b. DATE: 11/27/1959
23c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon Ce,.
23d. LOCATION (City, town, or county): St. Louis County (State): Mo.

24. FUNERAL DIRECTOR: Alexander & Sons
ADDRESS: 6175 Delmar Blvd.
25. DATE RECD. BY LOCAL REG.: NOV 27 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Jos. E McCullo

Licensed Embalmer No. 246

P. O. Address 6 13 [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con 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.