

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 2 1 7

FILED VS. DEC 30 1959 149

Registration District No. Primary Registration District No. 1002 Registrar's No.

5986

STATE FILE NUMBER

INDEXED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS City</u>		Length of stay in 1b <u>20 days</u>		c. CITY OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osteopathic Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>7069 Plymouth</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>H.</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>12.</u> Year <u>1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 1, 1910</u>	9. AGE (last birthday) <u>49</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>		11. BIRTHPLACE (City and state of country) <u>Tilden, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Stanis</u>			13b. MOTHER'S MAIDEN NAME <u>ANN KONOSKI</u>			14. NAME OF HUSBAND OR WIFE <u>George M. Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>492-12-8536</u>		17. INFORMANT Address <u>George M. Jones 7069 Plymouth</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Center Depression</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Intracerebral Hemorrhage</u> <u>20 days</u> DUE TO (c) <u>Hypertension &amp; Rupture of Berry Aneurysm</u> <u>20 days</u> 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	
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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	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 <u>Nov 22, 1959</u> to <u>Dec 12, 1959</u> and last saw her alive on <u>Dec 12, 1959</u> Death occurred at <u>9:05</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Bernice Jones</u>				22b. ADDRESS <u>926 E. 11th St.</u>			22c. DATE SIGNED <u>12-12-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Dec-12-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles</u>			23d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>			
24. FUNERAL DIRECTOR <u>Muehlebach</u>			ADDRESS <u>6800 BOST</u>		25. DATE RECD. BY LOCAL REG. <u>12.12.59</u>		26. REGISTRAR'S SIGNATURE <u>Drew Marshall</u>		

*On file at [unclear]*  
*[Signature]*

**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 *R. E. Nichols*

Licensed Embalmer No. *4997*

P. O. Address *K. P. Md*

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.