

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003621

FILED VS. FEB 10 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 996** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		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 St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5099 Page Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) Will	First	Middle	Last	4. DATE OF DEATH Month	Day	Year
			Jones	1	23	60

5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-12-1900	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months	IF UNDER 24 HR. Days	Hours	Min.
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---------------------------	-------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Tennessee	12. CITIZEN OF WHAT COUNTRY U.S.A
---	--	--	---

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Florence Jones
--------------------------------------	---	--

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. 49I-12-6807	17. INFORMANT Florence Jones 5099 Page	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lungs		INTERVAL BETWEEN ONSET AND DEATH Undet.
DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) Ascitis, Pleural Effusion		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 _____ 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 1-17-60 to 1-23-60	COUNTY	STATE
--	--	--	--------	-------

21. I attended the deceased from **1-17-60** to **1-23-60** and last saw **xxx** him alive on **1-23-60**.
Death occurred at **7:30** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Andrew A. Maxey MD</i>	(Deceased by title)	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 1-27-60
---	---------------------	---	------------------------------------

23a. BURIAL, CREMATION, or other final disposition (Specify) Burial	23b. DATE 1-30-1960	23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery	23d. LOCATION (City, town, or county) (State) 408 South Filmore I.O
---	-------------------------------	--	---

24. FUNERAL DIRECTOR E. J. Golden	ADDRESS 3404 Delmar Blvd,	25. DATE RECD. BY LOCAL REG. JAN 28 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
---	-------------------------------------	--	--

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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leroy W. Finnister

Licensed Embalmer No. 4523

P. O. Address 4251 W

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.