

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-004504

FILED VS FEB 1 1960 317

Registration District No. 317

Primary Registration District No. 590

Registrar's No. 229

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Berkely</b>		Length of stay in 1b <b>YRS.</b>		c. CITY OR TOWN <b>Berkeley</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5709 Onnie Rei</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5709 Onnie Rei Dr.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>May</b> Middle <b>Christine</b> Last <b>Jameson</b>			4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-18-96</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Hosp. Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>		
13a. FATHER'S NAME <b>Joseph Konertz</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Kaiser</b>			14. NAME OF HUSBAND OR WIFE <b>Jay W. Jameson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>486-22-4378</b>		17. INFORMANT <b>Elmer Jameson, Berkeley, Mo.</b>		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) <b>Abdominal Carcinomatosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Carcinoma of Endometrium</b>						<b>4 yr.</b>		
DUE TO (c)								
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>May 16, 1959</b> to <b>May 28, 1959</b> and last saw her alive on <b>Dec. 21, 1959</b>				Death occurred at <b>11:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>Wm. T. Newton M.D.</i> (Degree or title)			22b. ADDRESS <b>Barnes Hospital</b>			22c. DATE SIGNED <b>1/20/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-23-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>				
24. FUNERAL DIRECTOR <b>White-Mullen Mortuary, Ferguson,</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1-23-60</b>		26. REGISTRAR'S SIGNATURE <i>John B. McFay 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 my - self \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Reinhold K Lehman

Licensed Embalmer No. 3395

P. O. Address St Louis 35

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