RI	DΙ	VISION OF HEALTH - STANDARD CERTIFICATE OF DEATH		8 6	860-012759		
HDEC	• •	Registration District NoPrimary Registration Distric	t NoRegistrar's Net	2 3163	STATE FILE NUMBER		
	<u> </u>	1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDE a. STATE	NCE (Where deceased live		nce before mission)	
		TOWN St. Louis	h of stay in 1b c. CITY OR TOWN	PLouis		No 🗆	
		c. FULL NAME OF (If NOT in hospital, give location) D.O.A. HOSPITAL OR INSTITUTION Homer Dholles & Hospital	Inside Limits Yes 12 No [] d. STREET ADDRESS	5215 WA		de on Farm	
		3. NAME OF DECEASED First Middle (Type or print) ADA	JAMes	4. DATE Mor OF DEATH	3 - 17-	60	
		Female Negro Widowed	Divorced 8. DATE OF BIRTH	9. AGE (last birthday)	Months Days Hou		
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 13a. FATHER'S NAME 13b. MOTHER	ٔ مها س	(City and state or country)	12. CITIZEN OF WHAT	COUNTRY	
		Jim Delany So	Phie Delans	y Name Or	Address		
		(Yes, no, or unknown) (If yes, give way or dates of service)	Ione Rosie	Collins 52		L BETWEEN	
	DOCUMENT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMEDIATE CAUSE (a)					
	ŏ	Conditions, if any, which gave rise to above cause (a),	ralized C	arterio s	elevis		
	+	stating the under- lying cause last. DUE TO (c)	JING TO DEATH but not related to	the terminal PART I	Ii. If deceased was	female was	
		disease condition given in PART I (a)			there a pregnancy in	Unknown	
		BE PERFORMED?	b. DESCRIBE HOW INJURY OCCURRED). (Enter nature of injury in	PART I or PART II of iter	m 18.)	
-	: \	20c. TIME OF Hou Month, Day, Year INJURY	about home, 20f. CITY, TOWN, OF	LOCATION	COUNTY	STATE	
		WHILE AT WORK farm, factory, street, office bl.	dg., etc.)	. <u>.</u> .			
		21. I attended the deceased from 205	on the date stated above,	d last saw her alive on and to the best of my know	- 		
	VIT OF	Jacob Simon (Degree of Degree of Deg	22b. ADDRESS 300 METERY OR CREMATORY	Clark 23d. LOCATION (City, 10w)	3/	S/60	
	AFFIDAVIT	23a. BURIAL, CREMATION, 23b. DATE 23c. NAME OF CE REMOVAL (Specify) 3-22-60 24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL R	GRANADA,	MISSISSIPPI		
	BY /	J. Mc Olendon 4535 Washingto	MAR 18 1960		Smith .	M.D.	
		(Licensed E	mbalmer's Statement on Reverse Side)	,	m 96		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is re	corded on the reverse side of this certificate was embalmed by
or by	, Student Embalmer No
working under my personal supervision.	01600
StudentSignature of Student Embalmer	Signed Jefferson W Wends

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