

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-024496**

**FILED VS JUN 27 1960**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5912** STATE FILE NUMBER

Reviewed: Operation for removal of polypoid lesion  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4211 San Francisco</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>L.</b> Last <b>FRANCE</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>8/15/94</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>City of Clayton</b>		11. BIRTHPLACE (City and state or country) <b>Wentzville, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Henry France</b>			13b. MOTHER'S MAIDEN NAME <b>Emma</b>			14. NAME OF HUSBAND OR WIFE <b>Inez France</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>486-14-2114</b>		17. INFORMANT Address <b>Inez France 4211 San Francisco</b>			
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>Thrombosis of Left carotid artery</b> DUE TO (b) <b>trauma to artery during</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <b>craniotomy for hypophysectomy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to terminal disease condition given in PART I (a) <b>224x</b>							INTERVAL BETWEEN ONSET AND DEATH	
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.) <b>224x</b>				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
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.) <b>St. Louis, Mo.</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo.</b>		COUNTY <b>Mo.</b>		STATE
21. I attended the deceased from <b>5/29/60</b> to <b>5/60</b> and last saw <sup>her</sup> <b>him</b> live on <b>4/5/60</b> Death occurred at <b>2:45 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Clarence M. Benage</b>				22b. ADDRESS <b>Jewish Hospital</b>			22c. DATE SIGNED <b>6/6/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6/10/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b>			
24. FUNERAL DIRECTOR <b>Charles J. Gates 4107 Finney</b>				25. DATE RECD. BY LOCAL REG. <b>JUN 9 1960</b>		26. REGISTRAR'S SIGNATURE <b>Lead Smith, M.D.</b>		

*mgs*

**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 Myrtle Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.