

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024646

FILED VS JUL 12 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6535 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>	Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony Hosp.</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6252 Sunshine Dr.</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>E.</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1960</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Robert Mitchell</u>		13b. MOTHER'S MAIDEN NAME <u>Theodosia Reed</u>		14. NAME OF HUSBAND OR WIFE <u>unk</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>unk</u>	17. INFORMANT <u>St. Louis, Mo.</u> <u>Clifford A. Jones 6252 Sunshine Dr.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>ATELECTASIS of Lungs</u>		<u>2 months</u>
DUE TO (b) <u>Fracture of the right femur (shaft)</u>		<u>3 1/2 months</u>
DUE TO (c) <u>Fracture of the right femur (neck)</u>		<u>2 years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>6-29-60</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <u>904.7 46</u>	
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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.) <u>Fractured femur while undergoing surgery at</u>
20c. TIME OF INJURY Hour <u>3</u> a.m. <u>16</u> p.m.	Month, Day, Year <u>3-16-60</u>	

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>16 St. Anthony's Hospital</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Missouri</u>
21. I attended the deceased from <u>March 9, 1960</u> , to <u>JUNE 24, 1960</u> and last saw her/him alive on <u>JUNE 24, 1960</u> Death occurred at <u>2 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Andrew Lukno M. D.</u>	22b. ADDRESS <u>539 N. Grand, St. Louis 3, Mo.</u>	22c. DATE SIGNED <u>6-25-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal train</u>	23b. DATE <u>6-25-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Guthrie, Oklahoma</u>	23d. LOCATION (City, town, or county) (State) <u>Guthrie, Oklahoma</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 25 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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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 David Tom Fossam

Licensed Embalmer No. 4202

P. O. Address St. Louis Mo

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.