

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

**-60-028494**

FILED VS AUG 4 1960

318

1003

7233

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo.</u>		Length of stay in lb <u>13 hrs.</u>		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. Louis Children's</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3600 N. Newstead</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Fletcher</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>color</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-57</u>	9. AGE (last birthday) <u>2 years</u>	IF UNDER 1 YEAR Months _____ Days _____	
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>St. Louis Missouri</u>		
13a. FATHER'S NAME <u>Charles Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Marjorie Hardy</u>		14. NAME OF HUSBAND OR WIFE <u>none</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>none</u>		17. INFORMANT <u>Mary Ritter 500 S Kingshighway</u> 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) <u>Hemiation of base of brain</u> DUE TO (b) <u>Increased intracranial Pressure</u> DUE TO (c) <u>head encephalopathy</u> CONDITIONS (if any, which survive to above cause (a), stating the underlying cause last.) <u>7-20-60</u>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>885.6-14</u>			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 type="checkbox"/>	20a. ACCIDENT <input checked="" 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>ingested paint and plaster in home over period of unknown time.</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>unknown</u>					

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.) <u>10 home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u> , <u>Missouri</u>	
21. I attended the deceased from <u>7-17-60</u> to <u>7-17-60</u> and last saw her/him alive on <u>7-17-60</u> Death occurred at <u>7:10 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Rieser, M.D.</u> (Degree or title)		22b. ADDRESS <u>Children's Hospital</u>		22c. DATE SIGNED <u>7/18/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-20-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri</u>	
24. FUNERAL DIRECTOR <u>Ellis Funeral Home</u> ADDRESS <u>2820 Stoddard St.</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 20 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

30-7-6890

**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

*Gulley E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address

*St Louis*

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.