

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-029230
STATE FILE NUMBER

FILED VS. JUL 22 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2006

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KOCH MO		c. CITY OR TOWN ST LOUIS	
Length of stay in 1b 16 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ROBT KOCH HOSPITAL		d. STREET ADDRESS (If outside, give location) 4365 ST FERDINAND	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ANN Middle Last JONES			4. DATE OF DEATH Month JUNE Day 30 Year 1960		
5. SEX FEMALE	6. COLOR OR RACE NON WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec 1, 1880	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (City and state or country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME OSCAR WALLACE <i>deceased</i>		13b. MOTHER'S MAIDEN NAME FANNIE GOODE <i>deceased</i>	
14. NAME OF HUSBAND OR WIFE WALTER JONES <i>deceased</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 493-44-0302	
17. INFORMANT HOSPITAL RECORD - KOCH HOSPITAL		17. ADDRESS		17. ADDRESS	

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) PULMONARY INFARCTS			
DUE TO (b) PULMONARY ARTERY THROMBOSIS			
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) DIABETES MELLITUS			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 5:02 a.m. p.m.	Month, Day, Year JUNE 15/60	

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 ST. LOUIS	COUNTY MISSOURI	STATE
21. I attended the deceased from JUNE 15/60 and last saw her alive on JUNE 30/60 Death occurred at 5:02 A m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Frank Cohen (Degree or title) M.D.		22b. ADDRESS Robert Koch Hosp KOCH MO		22c. DATE SIGNED 6/30/60
23a. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	23b. DATE 7/6/60		23c. LOCATION (City, town, or county) (State) St. Louis County Missouri	
24. FUNERAL DIRECTOR C.W. Roberts Und.Co	24. ADDRESS 1416 N. Taylor Ave		25. DATE RECD. BY LOCAL REG. 7-3-60	26. REGISTRAR'S SIGNATURE John B. Maggley M.D.

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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James J. Carter

Licensed Embalmer No. *460*

P. O. Address *8200*

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.