

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 26 1960

-60-032419

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8150 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 <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in lb <u>2Wks</u>	c. CITY OR TOWN <u>Cantwell</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>LEROY</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>15</u> Year <u>1960</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lead Miner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Lead Mines</u>	11. BIRTHPLACE (City and state or country) <u>Washington Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Patton</u>	14. NAME OF HUSBAND OR WIFE <u>Anna Jones</u>
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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>Nil.</u>	17. INFORMANT <u>Anna Jones, Cantwell, Mo.</u>
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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>STAPHYLOCOCCAL PNEUMONIA, SUSPECTED</u>		<u>4 DAYS</u>
DUE TO (b) <u>CAPITATE FRACTURE OF LEFT HIP</u>		<u>5 WEEKS</u>
DUE TO (c) <u>902.1</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>45</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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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>PATIENT SUPPOSEDLY FELL FROM HAY LOFT ON HIS</u>
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20c. TIME OF INJURY Hour <u>3</u> Week <u>weeks prior</u> Day <u>to adm. here</u> Year <u>FARM</u>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>65 FARM</u>	20f. CITY, TOWN, OR LOCATION <u>CANTWELL</u>	COUNTY <u>MISSOURI</u>	STATE
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21. I attended the deceased from <u>AUGUST 2, 1960</u> to <u>AUGUST 15, 1960</u> and last saw her alive on <u>AUGUST 15, 1960</u> Death occurred at <u>11:55 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>C. D. Vannella, M.D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>8/16/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-18-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Caledonia, Mo.</u>
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24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 18 1960</u>	26. REGISTRAR'S SIGNATURE <u>Coal Smith, M.D.</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

HARRIS HOSPITAL

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 J. W. Bembler

Licensed Embalmer No. 3653

P. O. Address St. Louis 8

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.