

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If outside, give location) 8612 Halls Ferry	

3. NAME OF DECEASED (Type or print) First Infant Middle Last Jones			4. DATE OF DEATH Month November Day 8 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1960	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John A. Jones		13b. MOTHER'S MAIDEN NAME Sonya M. Solak		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT John A. Jones Address 8612 Halls Ferry	

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><i>Atelectasis of lungs</i></u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) _____ DUE TO (c) <u><i>Prematurity</i></u> 7625		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 COUNTY STATE
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21. I attended the deceased from *11/8/60* to *11/8/60* and last saw ^{her}/_{him} alive on *11/8/60*
 Death occurred at *3:30 AM* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u><i>Anthony V. Benimasa MD</i></u>	22b. ADDRESS <u><i>3731 Goodfellow Blvd</i></u>	22c. DATE SIGNED <u><i>11-9-60</i></u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-9-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR E.J. Schnur	ADDRESS 3125 Lafayette Ave.	25. DATE RECD. BY LOCAL REG. 11-9-1960	26. REGISTRAR'S SIGNATURE <u><i>Loan Smith, M.D.</i></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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Not Embalmed*
Bill Vallmer _____

Licensed Embalmer No. _____

P. O. Address _____

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.