SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-007155

STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 315

FILED VS FEB 20 1961

1. PLACE OF DEATH
a. COUNTY St. Louis County
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SKoch, Mo — Length of stay in 1b: 117 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hospital — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 2314 Cole — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Jessie Middle: Mae Last: Jones
4. DATE OF DEATH Month: Jan Day: 30 Year: 1961
5. SEX Female
6. COLOR OR RACE Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 9-28-87?
9. AGE (last birthday) ?73
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil
10b. KIND OF BUSINESS OR INDUSTRY Nil
11. BIRTHPLACE (City and state or country) Tenn
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Lee Jones
13b. MOTHER'S MAIDEN NAME Annie ??
14. NAME OF HUSBAND OR WIFE ?????
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
17. INFORMANT Records at Koch Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident (Recurrent)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Vascular Syndrome and Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 mos?
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Late Latent Lues with probable Paresis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 10-5-1960 to Jan 30th, 1961 and last saw her/him alive on 1-30-61
Death occurred at 9:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Harold G. Rueed MD (Degree or title)
22b. ADDRESS Koch Hospital, Koch Mo
22c. DATE SIGNED 1-30-61

23a. BURIAL, CREMATION, REMOVAL (Specify) ~~removal~~ BURIAL
23b. DATE 2-3-61
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
23d. LOCATION (City, town, or county) St. Louis County, (State) Mo.

24. FUNERAL DIRECTOR Dement & Son — ADDRESS 2629-31 Cole St.
25. DATE RECD. BY LOCAL REG. 2-1-61
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED 1/2 — INSTEAD OF — DOCUMENT — SHOULD READ — ITEM NO. — 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 W. Glaude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Fayette

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.