

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUN 16 1961

1578-61-023488

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1558

AMENDED

|   |  |   |   |  |   |  |
|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO.</b> b. COUNTY <b>St. Louis</b> |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Koch</b>  |  | Length of stay in 1b<br><b>17 days</b>  | c. CITY OR TOWN <b>St. Louis</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>3916 Lucas</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Dorothy</b> Middle <b>Allison</b> Last <b>Jones</b>   |  |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>1</b> Year <b>1961</b>   |  |   |  |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>C</b>              | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-2-23</b>  | 9. AGE (last birthday) <b>37</b>   | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>1</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nil</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Mo.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>  |  |
| 13a. FATHER'S NAME<br><b>Oliver Allison</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Leona</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Charlie Jones</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>No</b>  | 17. INFORMANT<br><b>Koch's Records</b>  |  | Address<br><b>Koch, Mo.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b>   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3</b>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |   | DUE TO (b)  |  | DUE TO (c)  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Shannan's cirrhosis</b>   |  |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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.) |   |  |
| 20c. TIME OF INJURY<br>Hour <b>3:30</b> Month, Day, Year <b>5-15-61</b><br>a.m. p.m.  |  | 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.)     | 20f. CITY, TOWN, OR LOCATION<br><b>Koch, Mo.</b>  |  |
| 20f. CITY, TOWN, OR LOCATION  |  | COUNTY  |   | STATE  |   |  |
| 21. I attended the deceased from <b>5-15-61</b> to <b>6-1-61</b> and last saw her alive on <b>6-1-61</b><br>Death occurred at <b>3:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |  |   |  |
| 22a. SIGNATURE<br><b>Bernard Friedman, M.D.</b> (Degree or title)   |  |   | 22b. ADDRESS<br><b>Robert Koch Hospital<br/>Koch, Mo.</b>   |  | 22c. DATE SIGNED<br><b>6-1-61</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>6-7-1961</b>           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Co. Mo.</b>                    |   |  |
| 24. FUNERAL DIRECTOR<br><b>J. H. RANDLE &amp; SON</b> ADDRESS <b>3133 Bell Ave.</b>   |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>6-3-61</b>   | 26. REGISTRAR'S SIGNATURE<br><b>John M. Murphy, M.D.</b>                                     |   |  |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Esther D. Harris

Licensed Embalmer No. 44258

P. O. Address 4181 Wash

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: