

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
 Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7362-61-026979** STATE FILE NUMBER

AMENDED

FILED AUG 14 1961

1. PLACE OF DEATH a. COUNTY				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 St. Louis			Length of stay in 1b 2 Wks.	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6021 Grimshaw Pl.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle I. Last Jones				4. DATE OF DEATH Month 8 Day 6 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/28/08	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cher			10b. KIND OF BUSINESS OR INDUSTRY McDonnell Corp.		11. BIRTHPLACE (City and state or country) Louisville, Ky.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME James A. Jones			13b. MOTHER'S MAIDEN NAME Alice (Unknown)			14. NAME OF HUSBAND OR WIFE Arline Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W W 2			16. SOCIAL SECURITY NO. W W 2		17. INFORMANT Address Mrs. Arline Jones, 6021 Grimshaw		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO (b) Myocarditis, Chronic DUE TO (c) 422.2 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH ? 3
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		
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.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
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
21. I attended the deceased from 1947 to Aug. 6, 1961 and last saw ^{him} alive on August 1, 1961 Death occurred at 7 P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) I. I. Berwald, M.D. ex officio				22b. ADDRESS 3409 North Union Blvd		22c. DATE SIGNED 8-8-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 8/9/61	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.			
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral, 1905 Union Blvd.				25. DATE RECD. BY LOCAL REG. AUG 8 1961		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

7/29

Dr. Joseph Ledermann
2400a N. Grand
Je 3-7366
Hrs. 8-12 Tues.

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 Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.