

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-038784
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10191

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 1 wk.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY _____
c. CITY OR TOWN St. Louis Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 4550 Washington Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Charlie Middle _____ Last Jones 4. DATE OF DEATH Month 10 Day 30 Year 61

5. SEX Male 6. COLOR OR RACE Col. 7. Married Never Married Widowed Sep. Divorced 8. DATE OF BIRTH About 70 9. AGE (last birthday) 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) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) Miss. USA 12. CITIZEN OF WHAT COUNTRY _____

13a. FATHER'S NAME Unk. Frank Jones 13b. MOTHER'S MAIDEN NAME Unk. 14. NAME OF HUSBAND OR WIFE Sallie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Sallie Jones-Barnard Hospital Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma prostate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) 177X

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. 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 10-23-61 to 10-30-61 and last saw her alive on 10-30-61
Death occurred at 11:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) Leut 22b. ADDRESS Chronic Hospital 22c. DATE SIGNED 10/31/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 11-2-61 23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem. 23d. LOCATION (City, town, or county) (State) Berkeley, Mo.

24. FUNERAL DIRECTOR A.L. Beal Und.Co. ADDRESS 4303 Delmar 25. DATE RECD. BY LOCAL REG. NOV 2 1961 26. REGISTRAR'S SIGNATURE [Signature]

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

May 20, 1962

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 Arthur P. Herliard

Licensed Embalmer No. 4221

P. O. Address 3100 Canton Ave

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.