

MISSOURI DEPARTMENT OF PUBLIC HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH

MISSOURI DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No. 1003

Registrar's No. 10768

-81-042575  
STATE FILE NUMBER

Registration District No. **FILED NOV 28 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>4010 Finney</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Susie E. Jones</b>			4. DATE OF DEATH Month Day Year <b>11 19 61</b>			
---	--	--	---	--	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/11/96</b>	9. AGE (last birthday) <b>65</b>	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (City and state or country) <b>Marianna, Ark.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	--	---	--

13a. FATHER'S NAME <b>Dave Randolph</b>	13b. MOTHER'S MAIDEN NAME <b>Alice Griggs</b>	14. NAME OF HUSBAND OR WIFE <b>Billy Jones</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>--</b>	17. INFORMANT Address <b>Kellie Crenshaw, 4223 E. Page</b>
--	--------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paraplegia of Unknown Etiology</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>352x</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) <b>Decubiti on Buttock</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 **8-8-61** to **11-19-61** and last saw her <sup>him</sup> ~~live~~ <sup>die</sup> ~~on~~ **11-19-61**  
Death occurred at **2:45** a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Charles P. Jones, M.D.</i>	22b. ADDRESS <b>2601 N. Whittier Street</b>	22c. DATE SIGNED <b>11-20-61</b>
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/22/61</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Clarksdale, Miss.</b>
---	------------------------------	------------------------------------	---

24. FUNERAL DIRECTOR ADDRESS <b>Charles J. Gates, 4107 Finney</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 20 1961</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
--	--	--

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gupton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.