

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028814

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7214 STATE FILE NUMBER

FILED JUL 31 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. NO.1</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2250 Cass Ave.</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jimmie</u> Middle <u>Lee</u> Last <u>Jones</u>						4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>62</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-38</u>		9. AGE (last birthday) <u>23</u>		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) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Smack over, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Grafton Ried</u>				13b. MOTHER'S MAIDEN NAME <u>Helen Goodwin</u>				14. NAME OF HUSBAND OR WIFE <u>Robert Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NIL</u>		17. INFORMANT Address <u>Grafton Ried Smackover, Ark.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Traumatic internal hemorrhage; Contrib:</u> <u>Shotgun wound of heart; suffered when shot with</u> <u>Shotgun in hands of one ROBERT JONES, in home at</u> <u>2250 Cass Ave., about 7:25 P.M., July 20th 1962.</u> DUE TO (c) <u>Homicide</u>										INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" 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 checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>See above</u>							
20c. TIME OF INJURY <u>7:25</u> a.m. <u>7-20-62</u> 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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo.</u>		COUNTY		STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Robert Jones Deputy</u>						22b. ADDRESS <u>1300 Clark</u>			22c. DATE SIGNED <u>7-23-62</u>		
22d. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE <u>7-24-1962</u>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) <u>Camden, Ark.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Anderson 4481 Finney Ave.</u>						25. DATE RECD. BY LOCAL REG. <u>JUL 23 1962</u>		26. REGISTRAR'S SIGNATURE <u>Robert Jones M.D.</u>			

**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

*Thomas M. Roberson*

Licensed Embalmer No.

*4479*

P. O. Address

*East St Louis, Ill*

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.