

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 14 1957

318

1003

18453
STATE FILE NUMBER
5209

Registration District No. _____ Primary Registration District No. _____ Registrar _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Reynolds.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis.		c. CITY OR TOWN Lesterville.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Bap. Hospital.		d. STREET ADDRESS (If outside, give location) 31	
3. NAME OF DECEASED (Type or print) First Johnny Middle A. Last Black		4. DATE OF DEATH Month June Day 2 Year 1957.	
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 Dec. 22, 1891.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Live Stock Dealer		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and state or country) Oats, Mo.
13. FATHER'S NAME Riley Black		14. MOTHER'S MAIDEN NAME Sarah Jane Foster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Address Ethel Kapelski, Maplewood, Ill.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 203x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
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. _____			
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 May 1956, June 2, 1957 and last saw ^{her} alive on June 2, 1957 Death occurred at 6:30 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In free or title) Richard Jones M.D.		22b. ADDRESS 3720 Washington	22c. DATE SIGNED June 3 '57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-3-57	23c. NAME OF CEMETERY OR CREMATORY Shys Cemetery	23d. LOCATION (City, town, or county) (State) Lesterville, Mo.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4704 Washington Blvd.		25. DATE RECD. BY LOCAL REG. JUN 3 '57	26. REGISTRAR'S SIGNATURE Earl Smith MD <i>m j b.</i>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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1956 12 NOV

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 Stanley A. [Signature]

Licensed Embalmer No. [Signature]

P. O. Address [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.