

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 30 1957

46272

STATE FILE NUMBER 12131

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

Health, Welfare & Public Services

300
1-56

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis, Mo.		c. CITY OR TOWN St Louis, Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 813 N 23rd Street		d. STREET ADDRESS (If outside, give location) 2219 813 N. 23rd St	
3. NAME OF DECEASED (Type or print) Leona Ross		4. DATE OF DEATH Month 12 Day 11 Year 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1911
9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	11. BIRTHPLACE (City and state or country) Langston Okla
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Lee Jones T	
14. MOTHER'S MAIDEN NAME Ella Brooks		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Address Alvie Jones, Button Willow Calf	
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 Infarction Hypertension DUE TO (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1			INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year 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 Berkely Mo		20g. COUNTY	
20h. STATE		21. I attended the deceased from Death occurred at 9 P. M. on 12/11/57	
22a. SIGNATURE Walter A. Young M.D.		22b. ADDRESS 2337 Market	
22c. DATE SIGNED 12/16/57		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 12-18-57		23c. NAME OF CEMETERY OR CREMATORY Washington Park	
23d. LOCATION (City, town, or county) Berkely Mo		23e. (State)	
24. FUNERAL DIRECTOR A. L. Beal Und Co. 4303 Delmar		25. DATE RECD. BY LOCAL REG. DEC 17 57	
26. REGISTRAR'S SIGNATURE J. Carl Smith MD		27. (State)	

(Licensed Embalmer's Statement on Reverse Side)

mgs.

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 *W. Claude Gordon*

Licensed Embalmer No. *34*

P. O. Address *4575 All*

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.