NOV 15 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2 791
1 1003

35773
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. .....

(b) Township ..... Primary Registration District No. ..... Registered No. 9350

(c) City St. Louis (d) Street No. 4190 West Belle Place St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lela Jackson

(a) Residence, No. 4190 West Belle Place St. 11
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Colored	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ?

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
Abt.	33	—	—	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housemaid
9. Industry or business in which work was done, as saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lexington, Mississippi.

FATHER
13. NAME Sepe Jackson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

MOTHER
15. MAIDEN NAME Parille Jefferson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

17. INFORMANT (ADDRESS) Mark D. Eagleton
4608 Tower Grove Place

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lexington, Miss. DATE Oct. 6 1937

19. FUNERAL DIRECTOR (ADDRESS) Robert J. Ambruster
Clayton Road at Concordia Lane.

20. FILED OCT 6 1937 19 J. F. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

No attending physician

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/3/37 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at 9:17 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Massive Cerebral Hemorrhage.	
Diffuse Arteriosclerosis.	
Chronic Parenchymatous Nephritis.	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify .....

(Signed) Alfred J. Perry, M.D.

(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

WRITE PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I. X12004

STATEMENT BY LICENSED EMBALMER

I, Robert J. Ambruster, Licensed Embalmer No. 1994

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Edward H. Bockhorst

L. E.

No. 2502 or by , Registered Apprentice No.

working under my personal supervision.

Signed Robert J. Ambruster

Licensed Embalmer No. 1994

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.)