

Registration District No. 1000 Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillins Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether _____)
In this community Unknown
years, months or days

3. (a) PRINT FULL NAME Andrew Jackson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race Ferro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna Jackson 6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased 1-5-1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 9 10 hr. min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____
12. Name Unknown
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature Arthur May...
(b) Address 2601 N. Chittier St.
17. (a) _____ (b) Date thereof 10-26-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Mrs Hamilton
(b) Address City Health Dept
19. (a) _____ (b) _____
(Signature of Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2627 Randolph (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 15
year 1939 hour 12:16 minute P M.

21. I hereby certify that I attended the deceased from 10-13-39, 1939 to 10-15-39, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration About 6 months
Chronic Nephritis About
Hypertensive Heart Disease 10 Yrs

Due to _____
Other conditions (Include pregnancy within months of death) _____
Major findings: 131
Of operations _____
Of autopsy Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Leon Smart (M. D. or other) _____
Address 2601 N. Chittier St. Date signed 10-18-1939

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.