

AR 7
No. 2
11-10-39
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FILED APR 1 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12357

Registration District No. 984

Primary Registration District No. 200

Registrar's No. 474

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Kash
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Kash Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 months
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Chester Jackson 250

8. (b) If veteran, name war No 8. (c) Social Security No. 490-14-9322

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9 23 1921
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
18 5 12 hr. min.

9. Birthplace St. Louis Missouri?
(City, town, or county) (State or foreign country)

10. Usual occupation Drugery Delivery Boy

11. Industry or business _____

12. Name C. Jackson

13. Birthplace Fredericktown Mo
(City, town, or county) (State or foreign country)

14. Maiden name Daisy Sweet

15. Birthplace Augusta Ill!
(City, town, or county) (State or foreign country)

16. (a) Informant Kash Hospital Records

(b) Address Kash, Missouri

17. (a) Burial (b) Date thereof 3-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director A. K. K...

(b) Address 2707 N. Grand St. St. Louis, Mo.

19. (a) MAR 7 1940 (b) [Signature]
(Date received local 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. 5053 Maple Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5
year 1940 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-5
_____, 1939, to 3-5, 1940
that I last saw him alive on 3-5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration _____

Due to 23

Due to _____

Other conditions Tuberculosis of Larynx
(Include pregnancy within 3 months of death) Tuberculosis of Pleura

Major findings: Of operations _____

Of autopsy Bilateral Pulmonary TB, e. cavitation
T.B. of Larynx T.B. of Pleura TB of

22. If death was due to external causes, fill in the following:
(a) 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? _____

707 While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. Ullman Stamba (M. D. or other) _____
Address Kash Hospital, Kash Mo Date signed 3-6-40

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

MOTHER FATHER

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 *Paul H. Kwoelenberg*

Licensed Embalmer No. *2631*

P. O. Address *2707 N. Lincoln*

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.