

## STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

6104

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County \_\_\_\_\_  
 (b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
BARNES HOSPITAL /  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 43 days  
(Specify whether years, months or days)

In this community \_\_\_\_\_

(Specify whether years, months or days)3. (a) PRINT FULL NAME How Allen Jackson 250

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none4. Sex Male5. Color or race White6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Emma Jackson

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar. 23 1866(Month)(Day)(Year)

8. AGE:

Years

Months

Days

If less than one day

7432318

hr. \_\_\_\_\_

min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_

(City, town, or county)(State or foreign country) Mo. 010. Usual occupation Cabinet maker11. Industry or business retired12. Name UnknownUnknown

13. Birthplace \_\_\_\_\_

(City, town, or county)(State or foreign country)14. Maiden name Unknown(City, town, or county)(State or foreign country)

15. Birthplace \_\_\_\_\_

(City, town, or county)(State or foreign country)16. (a) Informant's own signature R. J. Simmons(b) Address Charleston Mo.17. (a)  Burial(Burial, cremation, or removal)(b) Date thereof 7-22-40(Month) (Day) (Year)(c) Place: burial or cremation Bellefontaine Cem.18. (a) Signature of funeral director Drehmann Harral(b) Address 1905 Union Blvd19. (a) JUL 22 1940(Date received local registrar)J. F. Brudick  
(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town Charleston Mo N.R.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 0  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 19  
year 1940 hour 1 minute 15 A.M.21. I hereby certify that I attended the deceased from 6-8-1940  
19\_\_\_\_, to 7-19-1940  
that I last saw him alive on 7-19-1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Carcinoma of Prostate

Duration

7 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations As aboveOf autopsy As above

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

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? \_\_\_\_\_

While at work? \_\_\_\_\_

(Specify type of place)(e) Means of injury 123. Signature M. W. Jackson (M. D. or other) \_\_\_\_\_Address BARNES HOSPITALDate signed 7-19-40

SEP 28 1944

**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: *R. W. Sanford*  
Licensed Embalmer No. *2273*  
P. O. Address *St Louis*

**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.