

33583

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 8260

Registration District No. 791

Primary Registration District No. 1003

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: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether
In this community. Life Time (Specify whether
years, months or days)

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. Hamilton Hotel (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT-
FULL NAME George Vest Jackson

3. (b) If veteran, name was none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife. Mary L. Jackson 6. (c) Age of husband or wife if alive. 53 years
7. Birth date of deceased. June 10 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 3 23 hr. _____ min.

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

10. Usual occupation Retired R.R. Employee

11. Industry or business Railroading

MOTHER FATHER { 12. Name George P. B. Jackson.

13. Birthplace Thiabadeax La.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ellen Vest
15. Birthplace Boonville Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. G. P. Jackson

(b) Address Hamilton Hotel

17. (a) Burial (b) Date thereof 10/4/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Wagoner Und Co

(b) Address 3621 Olive St.
OCT 4 1940

19. (a) _____ (b) _____
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3
year 1940 hour 5:10 minute A M.

21. I hereby certify that I attended the deceased from September 24, 1940, to October 3, 1940;

that I last saw h _____ alive on _____, 19 _____;

and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia, bilateral Duration _____

Due to Diabetes, mellitus

Due to _____

Other conditions Epileptiform state?!
(Include pregnancy within 9 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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 _____

28. Signature J. B. Bradley (M. D. or other) _____

Address BARNES HOSP Date signed 10-3-40

USE CARBONING BACK INK—MAKE A 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ~~XXXXXX~~.....

Robert T. Sangster.....

Registered Apprentice No. 259.....

working under my personal supervision.

Signed

Neville D. Schwitter

Licensed Embalmer No. 3696.....

P. O. Address 3621 Olive St......

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.