No. 2
-13-40
-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41083

Registration District No. 791 | Primary Registration District No. 1003 | Registrar's No. 10854

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 16 days (Specify whether years, months or days)
In this community /

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town CAPE GIRARDEAU 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.

3. (a) PRINT FULL NAME Sidney Spratt Jackson
3. (b) If veteran, name war WORLD WAR
3. (c) Social Security No. 490-05-4629
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ANNA
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased July (Month) 30 (Day) 1892 (Year)

8. AGE: Years	Months	Days	If less than one day
48	9	24	hr. min.

9. Birthplace KENTUCKY (City, town, or county) (State or foreign country)
10. Usual occupation SHOE WORKER
11. Industry or business /

MOTHER FATHER
12. Name CHAS. A JACKSON
13. Birthplace HOPKINSVILLE (City, town, or county) KENTUCKY (State or foreign country)
14. Maiden name Unk.
15. Birthplace KENTUCKY (City, town, or county) (State or foreign country)

16. (a) Informant MRS. SIDNEY JACKSON
(b) Address CAPE GIRARDEAU
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-26-40 (Month) (Day) (Year)
(c) Place: burial or cremation CAPE GIRARDEAU
18. (a) Signature of funeral director Wm Schumacher
(b) Address 3013 Meramec
19. (a) DEC 31 1940 (Date received local registrar) (b) J M Bredech (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23 year 1940 hour 11 45 minute A M.
21. I hereby certify that I attended the deceased from Dec 7, 1940, to Dec 23, 1940; that I last saw him alive on Dec 23, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Multiple Abscesses — Duration
Due to Postoperative infection
Due to Bronchopneumonia
Due to operation for carcinoma of lower lip
Other conditions (Include pregnancy within 3 months of death) /
Major findings:
Of operations As above
Of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Jas M Parks (M. D. or other) M D
Address BARNES HOSPITAL Date signed 12-23-40

(Licensed Embalmer's Statement on Reverse Side)

10854

10854

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 George H. Archambault, Registered Apprentice No. ..... working under my personal supervision.

Signed George H. Archambault

Licensed Embalmer No. 2906

P. O. Address 3013 Meram

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.