

No. 2
1-4-41
-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30168

FILED OCT 18 1941

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 7507

1. PLACE OF DEATH:

(a) County St. Louis Mo
(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: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St Louis 21 17
(If outside city or town limits, write "RURAL")
(d) Street No. 29 32 Cass, E
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARIE LINE JACKSON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Thomas Jackson 6. (c) Age of husband or wife if alive 22 years
7. Birth date of deceased 8-5-1921
(Month) (Day) (Year)

8. AGE: Years 20 Months 1 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name FRANK MORGAN
13. Birthplace Dungen Miss
(City, town, or county) (State or foreign country)
14. Maiden name ANNIE BELL WILLIAMS
15. Birthplace Alligator Lake Miss
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Jackson
(b) Address 2933 Cass Ave
17. (a) Burial (b) Date thereof 9-17-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Mary Duke
(b) Address 4202 Junkey Ave
19. (a) SEP 17 1941 (b) J. N. Bickel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9th day 13th
year 1941 hour 7 minute 20 P. M.
21. I hereby certify that I attended the deceased from 9-10 1941 to 9-13 1941;
that I last saw her alive on 9-13 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia Duration _____
Due to Generalized peritonitis
Due to Below abscess cause unknown

Other conditions (Include pregnancy within 3 months of death) 1
Major findings: Of operations 1390
Of autopsy 1391
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) _____ (2) Means of injury 0
23. Signature D. E. Keenan (M. D. or other) _____
Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 15 1945

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. *269*

P. O. Address *2769 Howard*

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, fact should be so stated above.