

FILED APR 20 1942

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:  
(a) County St. Louis Mo.  
(b) City or town St. Louis Mo.  
(c) Name of hospital or institution: BARNES HOSPITAL 0  
(d) Length of stay: In hospital or institution 1 week  
In this community 1 week

2. USUAL RESIDENCE OF DECEASED:  
(a) State Illinois (b) County Williamson  
(c) City or town Marion  
(d) Street No.  
(e) Citizen of foreign country? No  
If yes, name country 2

3. (a) PRINT FULL NAME Franklin Benjamin Jackson  
(b) If veteran, name war  
(c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 12  
year 1942 hour 9 minute 11 A.M.  
21. I hereby certify that I attended the deceased from April 6, 1942, to April 12, 1942  
that I last saw him alive on April 12, 1942  
and that death occurred on the date and hour stated above.

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Susan 6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased March 6 1872

Immediate cause of death Cerebral hemorrhage  
Due to 85 00  
Due to 85 11  
Other conditions Hypertension - Generalized arteriosclerosis, auricular fibrillation  
Major findings: Of operations

8. AGE: Years 70 Months 1 Days 6  
If less than one day hr. min.

9. Birthplace Marion Ill.  
10. Usual occupation Coal miner

PHYSICIAN  
Underline the cause to which death should be charged statistically.

11. Industry or business  
12. Name Thomas Jackson  
13. Birthplace Ill.  
14. Maiden name Unknown  
15. Birthplace Ill.

16. (a) Informant Luther Hobbs  
(b) Address Marion Ill.  
17. (a) Removal (b) Date thereof 4/15/42  
(c) Place: burial or cremation Marion, Ill.

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?  
(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  
3. Signature C. E. Fischer (M. D. or other)  
Address BARNES HOSPITAL Date signed 4/12/42

18. (a) Signature of funeral director Albert H Hoppe  
(b) Address 4700 Washington  
19. (a) APR 15 1942 (b) J. P. Budek  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

333713  
333713

**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..... *W. Wilkins*.....  
Licensed Embalmer No..... 3575.....

P.O. Address.....

**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.**