

Registration District No. 111

Primary Registration District No. 111

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town Richmond Heights  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Mary's O  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 1/2 hrs.  
 (Specify whether  
 In this community Life  
 years, months or days)

3. (a) PRINT FULL NAME Barbara Jackson

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife. — 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased April 18 1942  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 3 — hr. — min.

9. Birthplace St. Louis Mo. O  
 (City, town, or county) (State or foreign country)

10. Usual occupation —

11. Industry or business —

MOTHER FATHER { 12. Name Eazel Jackson  
 13. Birthplace St. Louis Mo. O  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Hazel Carter  
 15. Birthplace Vanduser Mo. O  
 (City, town, or county) (State or foreign country)

16. (a) Informant Hazel Jackson  
 (b) Address 1919th Park

17. (a) — (b) Date thereof July 22-42  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation near St. Marcus

18. (a) Signature of funeral director A. W. McLaughlin  
 (b) Address 2301 Lafayette

19. (a) JUL 21 1942 (b) —  
 (Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000  
 (c) City or town St. Louis 17  
 (If outside city or town limits, write "RURAL") 7  
 (d) Street No. 1919th Park  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21st  
 year 1942 hour 2 minute 50 M.

21. I hereby certify that I attended the deceased from July 20th at 8:30 PM 1942 to 2:50 AM 7-21 1942  
 that I last saw her alive on July 21st 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia 5 days  
 Duration

Due to 108  
 Due to —

Other conditions —  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations —

Of autopsy Consolidation Lower Lobe Left + Lower Middle Rt.

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 —

23. Signature Raymond T. Martin (M. D. or other) MD  
 Address St. Mary's Hospital Date signed 7-21-42

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

96  
8  
3

FILED JUL 21 1942

**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.....

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.**

McLaughlin Funeral Home  
Undertaking Co.  
Address 2301 Lafayette Ave  
St. Louis, Mo.

EMBALMER'S CERTIFICATION

This is to certify that I, the undersigned, a licensed embalmer, personally and efficiently embalmed the following described cadaver:

Full name Barbara Jean Jackson Race W.

Place and date of death St. Mary's Hospital

Physician (or Coroner) signing Certificate

Place and date of Embalming St. Louis Mo 7/21/42

Remarks

Signed L.R. Cooper Missouri License No. 3655

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25288

Registration District No. 784

Primary Registration District No. 111

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

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 1/2 mo.  
(Specify whether \_\_\_\_\_)  
In this community St. L.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Barbara Jackson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month July day 21  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 18 1894  
(Month) (Day) (Year)

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

8. AGE: Years \_\_\_\_\_ Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation \_\_\_\_\_  
11. Industry of business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

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