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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 8392

Primary Registration District No. 1003

FILED OCT 2 1943 18

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town SAINT LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
HOMER G. PHILLIPS
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 HOURS
(Specify whether)

In this community LIFE
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____

(c) City or town SAINT LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 4234 WEST EVANS AVE.
(If rural, give location)

(e) Citizen of foreign country? NE (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN L. JACKSON

3. (b) If veteran, name war, NO

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 17
year 1943 hour 11 minute 00 P.M.

4. Sex MALE

5. Color or race NEGRO

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 DECEMBER 1 1942
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
_____ hr. _____ min.
9 16

Immediate cause of death
Musculo-skeletal
disorders

Due to malnutrition

Due to _____

Other conditions (Include pregnancy within 3 months of death)
119

9. Birthplace SAINT LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER

12. Name ROBERT JACKSON

13. Birthplace INVERNESS MISSISSIPPI
(City, town, or county) (State or foreign country)

14. Maiden name ERNESTINE McQUARRY

15. Birthplace INVERNESS MISS.
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant ROBERT JACKSON

(b) Address 4234 WEST EVANS

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?

17. (a) BURIAL (b) Date thereof 9-22-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK

18. (a) Signature of funeral director CHARLES J. GATES

(b) Address 4107 FINNEY AVE.

While at work? _____ (Specify type of place)

(c) Means of injury 3

23. Signature W. H. Brown (M. D. or other)
Add Deputy Coroner Date signed 9/30/43

19. (a) SEP 21 1943 (b) J. F. Baeseck
(Date received local registrar) (Registrar's signature)

844

(Licensed Embalmer's Statement on Reverse Side)

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.....

Thomas J. [Signature]

Licensed Embalmer No. *4259*

P. O. Address *4107 Juney Ave*

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.