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

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC AFFAIRS
FILED FEB 27 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

479

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **364**

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

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

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 291

(d) Street No. 1834a O'Fallon
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Charles Lee Jackson

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

4. Sex Male 2 Color Col 5. Color Col 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 24 years (Day) (Year)

7. Birth date of deceased June 24 1943
(Month) (Day) (Year)

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

9. Birthplace St. Louis MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

12. Name Jimmie Jackson

13. Birthplace St. Louis MO 0
(City, town, or county) (State or foreign country)

14. Maiden name Madeline Smith

15. Birthplace St. Louis MO 0
(City, town, or county) (State or foreign country)

16. (a) Informant Fannie Buckner
(b) Address 1834a O'Fallon St

17. (a) Burial (b) Date thereof Jan 13 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director F. A. Green
(b) Address 2915 Franklin Ave.

19. (a) JAN 13 1944 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11, year 1944 hour 2 minute 35 A. M.

21. I hereby certify that I attended the deceased from January 3, 1944 to January 11, 1944; that I last saw him alive on January 11, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Right Lobar Pneumonia - Primary Duration 1 mo.

Due to.....

Due to..... 108

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 C. Raymond Mery (M.D. or other) 2601 N. Whittier Date signed 1/11/44

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

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

G. A. Allen

Licensed Embalmer No.

2963

P. O. Address

2915 Franklin 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.