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X35697

FILED FEB 18 1944

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State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 983

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town St Louis
(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 1 mo; 14 days
(Specify whether years, months or days)

In this community 20 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 12

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

(d) Street No. 2602 Pine St
(If rural, give location)

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

3. (a) PRINT FULL NAME Clarence Jackson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25
year 1944 hour 10 minute 25 P.M.

4. Sex Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 28 1889
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 15, 1944 to January 25, 1944; that I last saw him alive on January 25, 1944; and that death occurred on the date and hour stated above.

8. AGE: Years 54 Months 3 Days 27 If less than one day hr. _____ min. _____

9. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Shoe Shiner

11. Industry or business _____

Immediate cause of death Hypertensive Heart Disease Duration Unknown

Due to _____

Due to _____

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

MOTHER FATHER

12. Name Jeff Jackson

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Virginia (Unknown)

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant St Coleman

(b) Address Homer G Phillips Hospital

17. (a) Anatomical Date thereof 1-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. August

18. (a) Signature of funeral director W. K. Rutledge

(b) Address 358 Rutledge

19. (a) (Date received local registrar) _____ (Registrar's signature) W. K. Rutledge

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) _____

(e) Means of injury _____

23. Signature E. Smith (M. D. or other) _____

Address 2601 N Whittier St Date signed 1-27-44

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

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.