

FILED SEP 8 1944  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(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 26 Days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 908 N. 20th Street  
(If rural, give location)

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

3. (a) PRINT FULL NAME Rosalind Marie Jackson

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 8  
year 44 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from 6 - 12  
19 44 to 7 - 8, 19 44  
that I last saw her alive on 7 - 8, 19 44  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced, Twin #1

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 6 12 44  
(Month) (Day) (Year)

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

Due to Unknown

Due to Unknown

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
26 hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name Ethel Jackson

15. Birthplace Gloster Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant Esther M. Sherard, R.N.

(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof AUG 24 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director James Owens

(b) Address City Health Dept

19. (a) AUG 23 1944 (b) J. F. Bredeck  
(Date received local registry) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature J. H. Sunkler (M. D. or other) \_\_\_\_\_  
Address 2601 N. Whittier St. Date signed 8-21-44

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

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**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.**