

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. *398*

*398*

FILED FEB 7 1948

Registration District No. \_\_\_\_\_

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

Registrar's No. *8517*

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 4 days (Specify whether  
In this community 7 yrs (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Eva Jackson

3. (b) If veteran, name war. \_\_\_\_\_ 3. (c) Social Security No. 100K

4. Sex Female 5. Color or race negro 6. (a) Single, widowed, married, divorced divorced

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

7. Birth date of deceased Aug. 27-1900  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
44 4 28 hr. min.

9. Birthplace Memphis Tenn  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

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

12. Name William Jackson

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

14. Maiden name unknown  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Anna Adams

(b) Address 4418 Garfield ave

17. (a) Burial (b) Date thereof 1-27-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Arthur Pro

(b) Address 3644 Funnery ave

19. (a) JAN 26 1945 (Date received local registrar) J. F. Bredeh (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4311 1/2 Evans Ave  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 24  
year 1945 hour 10 minute 05 A.M.

21. I hereby certify that I attended the deceased from January 20, 1945 to January 24, 1945  
that I last saw her alive on January 24, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Accident

Due to \_\_\_\_\_ Duration 5 days

Due to \_\_\_\_\_

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? \_\_\_\_\_

While at work? (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Anna Moore (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed 1-25-45

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

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

MOTHER FATHER

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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 Rorris V. Atkins

Licensed Embalmer No. 2842

P. O. Address 3644 Finley 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.**