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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 28 1945

State File No. 22107

Registration District No. 318 Primary Registration District No. 1005 Registrar's No. 6142

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Enroute to Homer G Phillips Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 7 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St Louis 17 (If outside city or town limits, write "RURAL")
(d) Street No. 217 a So 23rd St 9 (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARK JEFFERSON
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mamie Jefferson
6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased April (Month) 2 (Day) 1887 (Year)

8. AGE: Years 58 Months 3 Days 9 If less than one day hr. min.

9. Birthplace (City, town, or county) Miss (State or foreign country)
10. Usual occupation Labor
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant Mamie Jefferson
(b) Address 217 a So 23rd St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17/45 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cem
18. (a) Signature of funeral director F. A. Sheer
(b) Address 2915 Franklin ave
19. (a) JUL 16 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11 year 1945 hour 6 minute 10 P. M.

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

Immediate cause of death Internal hemorrhage from laceration of heart when he was struck by a truck being driven by one William McClain Col in front of 502 Chouteau Ave Ground 6:10 P.M. July 11 1945

Duration

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 170
Of autopsy 21

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) Accident
(b) Date of occurrence July 11, 1945 000
(c) Where did injury occur? St Louis (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Street (Specify type of place)
While at work? (e) Means of injury as above

23. Signature [signature] (M. D. or other)
Address [signature] Date signed 7/16/45

(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 G. A. Green

Licensed Embalmer No. 2963

P. O. Address 295 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.