

FILED JAN 18 1946
Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 178

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: St. Mary's Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair
(c) City or town E. St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1103 Division Ave.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SAM JACKSON

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Lovie Jackson 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Sept. 14, 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 3 20 hr. min.

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

10. Usual occupation Laborer

11. Industry or business Unemployed

MOTHER } 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Lovie Jackson
(b) Address 1103 Division

17. (a) Removal (b) Date thereof 1-5-46
(City, town, or county) (Month) (Day) (Year)
E. St. Louis, Ill., Booker Wash Cem.
(c) Place: burial or cremation

18. (a) Signature of funeral director C. J. Wash
(b) Address 417 1/2 St.

19. (a) JAN 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 3,
year 1946 hour 6 minute 30P. M.

21. I hereby certify that I attended the deceased from 4-1-45
to 1-2-46, 19____, to 1-2-46, 19____,
that I last saw him alive on 1-2-46, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death: Cholera
Duration 1 1/2 hrs

Due to _____

Due to _____

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

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? _____

While at work? _____ (Specify type of injury)
(e) Means of injury Cholera

23. Signature [Signature] (M. D. or other) MD

Address 1421 Kansas Date signed 1/5/46

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

2646

0
7
9

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..... *C. J. Nash*.....
Licensed Embalmer No. *2432*.....
P. O. Address..... *117113th St*.....

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.