No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3529

FILED FEB 13 1947

Registration District No. 13 1947 Primary Registration District No. 6076 Registrar's No. 263

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

2-10-47

1. PLACE OF DEATH

(a) County St. Louis Koch Mo.

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 640 Days (Specify whether)

In this community 640 Days (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 4104 Enright (If rural give location) 9

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Wesley Jackson

3. (b) If veteran, name war No

3. (c) Social Security No. 269-10-2104

4. Sex Male 2

5. Color or race Negro

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

6. (b) Name of husband or wife Jennie Heard

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

7. Birth date of deceased 1 (Month) 5 (Day) 98 (Year)

8. AGE: Years 48 Months 11 Days 28 If less than one day hr. min.

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

10. Usual occupation Pullman Porter

11. Industry or business

FATHER
12. Name James M. Jackson
13. Birthplace (City, town, or county) Miss (State or foreign country)

MOTHER
14. Maiden name Mattie Carter
15. Birthplace (City, town, or county) Miss (State or foreign country)

16. (a) Informant Hosp. Records

(b) Address Koch Hosp. Koch Mo.

17. (a) Motor (Burial, cremation, or removal) (b) Date thereof 2-7-47 (Month) (Day) (Year)

(c) Place: burial or cremation Forristell Mo.

18. (a) Signature of funeral director O. T. Nash

(b) Address 3847 Page

19. (a) 2-6-47 (Date received local registrar) (b) Ruth J. Allen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 3 year 47 hour 5 minute 25 p M.

21. I hereby certify that I attended the deceased from 5-4-45, 1945, to 2-3, 1947; that I last saw him alive on 2-3, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis due to Perforated Peptic Ulcer — Duration About 5 Days

Due to

Due to 117-a

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Peritonitis and Perforated Peptic Ulcer

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Russell Huder (M. D. or other) M.D.

Address Koch Hosp. Koch, Mo. Date signed 2-3-47

(Licensed Embalmer's Statement on Reverse Side)

FEB 19 1947

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. T. Nash

Licensed Embalmer No. 2432

P. O. Address 3847 Page

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.