

S. No. 2
 00M-5-43
 Rev. 5-17-39
 I X38671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED FEB 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. **1626**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
 (a) County **St. Louis**
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2629 a Barnard
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community **20 yrs.**
years, months or days

3. (a) PRINT FULL NAME **Geneva Ellen Jackson**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Negro**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **July 17, 1891**
(Month) (Day) (Year)

8. AGE: Years **55** Months **7** Days **26**
If less than one day
 hr. _____ min. _____

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

10. Usual occupation **None**

11. Industry or business _____

12. Name **Ervin Thompson**
 13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Flora Burkhalter**
 15. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Madeline Tucker**
 (b) Address **2629 a Barnard**

17. (a) **Burial** (b) Date thereof **2/18/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Dement & Son**
 (b) Address **2629-31 Cola St.**

19. (a) **FEB 17 1947** (b) **J. F. Bures**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **St. Louis**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2629 a Barnard St.**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **13**
 year **1947** hour **10** minute **30** M.
 21. I hereby certify that I attended the deceased from **2-10-47**
2 10 19**47** to **2-13-47**
 that I last saw her alive on **2-13-47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal obstruction**
 Duration **4**
 Due to _____
 Due to _____
 Other conditions **WJ**
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy **no.**

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 place) (e) Means of injury
 23. Signature **Dr. Edward Bell** (M. D. or other)
 Address **29012 Laclede ave.** Date signed **2-14-47**

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

MOTHER FATHER

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.....

H. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address. *46-75 Aldene*

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.