

S. No. 2
1-1/47
5-17-39

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

39797

National Office of Vital Statistics

State File No. 11267

FILED DEC 15 1947

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Hiram Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10/25/45 to 12/7/47
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County aaa
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 5800 Arsenal St. 9
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME MATA JACKSON
3. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 7
year 1947 hour 10 minute 15 P.M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife Charles C. Jackson
6. (c) Age of husband or wife if alive.....years
7. Birth date of deceased May 22 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 1, 1947, to Dec. 7, 1947
and that death occurred on the date and hour stated above. Dec. 7, 1947
Duration

8. AGE: Years Months Days If less than one day
86 6 15 hr. min.

Immediate cause of death Generalized arteriosclerosis especially cerebral
Due to senility, psychosis
decubitus ulcers

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

Other conditions within 3 months of death
Major findings: 97
Of operations.....
Of autopsy as above

10. Usual occupation Housewife

11. Industry or business
12. Name Martin Hoagland
13. Birthplace Kentucky
(City, town or county) (State or foreign country)
14. Maiden name Marie Jones
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

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

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof Dec 10 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hiram Cemetery

18. (a) Signature of funeral director Shepard Funeral Home
(b) Address 1167 Hamilton Avenue

19. (a) DEC 9 - 1947 (b) J. F. Bruesch
(Date received local registrar) (Registrar's signature)

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? (Specify type of place).....
(e) Means of injury 0
23. Signature H. P. Shroyer (M. D. or other) 0
Address 5800 Arsenal Date signed 12-8-47

WRITE PLAINLY—USING 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..... *Elmo R. Cadwell*

Licensed Embalmer No. *4077*

P. O. Address.....

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.