

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

20999
State File No. 5890
Registrar's No.

FILED JUL 15 1948 318
Registration District No.

Primary Registration District No.

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether
In this community FIVE YEARS
years, months or days)

3: (a) PRINT FULL NAME Elijah Jackson

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

4. Sex MALE 5. Color or race COL 6. (a) Single, widowed, married, divorced WIDOWED

6: (b) Name of husband or wife DEAD 6: (c) Age of husband or wife if alive DEAD years

7. Birth date of deceased (Month) DEC. (Day) 25. (Year) 1904

8. AGE: Years 63 Months 6 Days 2 If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business MILKER PLACE

12. Name WAM JACKSON

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

14. Maiden name DONT KNOW

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

16: (a) Informant Walter Taylor

(b) Address 4566 Mc MILLAN

17: (a) BURIAL (b) Date thereof 6-2-48
(City, town, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation ST. PETERS ST. PATRICKS CHURCH

18: (a) Signature of funeral director Elmer S. Keller

(b) Address 3080 ELY AVE

19: (a) JUL 1 1948 (b) J. F. Bredek
(Date recorded) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gas
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4560 McMillan
(If rural, give location)
(e) Citizen of foreign country? U.S.A. (Yes or No)
If yes, name country U.S.A.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
year 1948 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from
April 27, 1948 to June 15, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic
Gangrene and Hypertension Duration Undet.

Due to.....
Due to.....

Other conditions Old right hemiplegia
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy None

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) Means of injury.....
23. Signature Oscar L. Davids (M: D. or other)
Address 2601 N Whittier Date signed 6/28/48

MOTHER FATHER

Aug 21 1948

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 *Arthur L Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *4049 St Ferdinand*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.