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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 12 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34297**
Registrar's No. **9481**

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Home Phillips
(If not in hospital or institution, write street number or location) Two hours
(d) Length of stay: In hospital or institution Two hours
In this community Two hours
years, months or days

3: (a) PRINT FULL NAME Samuel Jackson Jr
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Col
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 30 1947
(Month) (Day) (Year)

8. AGE: Years I Months 3 Days 0
If less than one day hr. _____ min. _____

9. Birthplace St. Louis MO
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Jackson Sr
13. Birthplace Clarksdale Miss
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Mary Jones
15. Birthplace Fountian Ala.
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel Jackson Sr
(b) Address 3437 Lasalle St

17. (a) Burial (b) Date thereof Nov 22 48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. B. Lasater
(b) Address 2709 Chouteau

19. (a) NOV 1 1948 (b) J. B. Lasater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County W.C.
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3437 Lasalle 9
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 30
year 1948 hour 7:30 minute P M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertrophic Congenital Endocarditis
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? _____

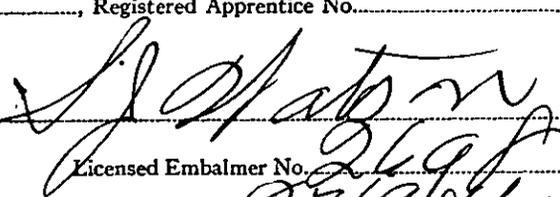
23. Signature Patrick E. Taylor, M.D.
Address 1500 Clark Date signed 11-1-48
(Specify type of place) (c) Means of injury _____

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



Licensed Embalmer No. 2698

P. O. Address.....

2969 Chow

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.

PLATE 1742