

FILED DEC 4 1948
Registration District No. **277**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution 871 days
(Specify whether _____)

In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 4225 Papin
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JACKSON, THELMA

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 Divorced

6. (b) Name of husband or wife Calvin Morse (divorced)

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

7. Birth date of deceased November 29 1921
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>26</u>	<u>11</u>	<u>14</u>	_____ hr. _____ min.

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

10. Usual occupation Secretary

11. Industry or business _____

12. Name Isiah Carter

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

14. Maiden name Amanda Collins

15. Birthplace Little Rock Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Records

(b) Address Robert Koch Hospital

17. (c) Burial (Burial, cremation, or removal)

(b) Date thereof 11-17-48
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Bernice Lane

(b) Address 3103 Washington

19. (a) 11-17-48 (Date received local registrar)

(b) Beulah J. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 12
year 1948 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 6-25-46, 19____, to 11-12-48, 19____;
that I last saw her alive on 11-12-48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Duration 8 1/2 yrs. (???)

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? _____

While at work? _____ (Specify type of place)

(b) Means of injury D.

23. Signature Harold G. Russell (M. D. or other)

Address Robert Koch Hospital Date signed 11/13/48

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 *4575 Aldine*

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.