

FILED JUL 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21208

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5565**

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY MO c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS d. STREET ADDRESS (If rural, give location) 3915 Windsor	
3. NAME OF DECEASED a. (First) Charlie b. (Middle) _____ c. (Last) Jackson		4. DATE OF DEATH (Month) (Day) (Year) June 25 1949	
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG 2 1898
9. AGE (In years last birthday) 50		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	10b. KIND OF BUSINESS OR INDUSTRY LEXINGTON MISS
11. BIRTHPLACE (State or foreign country) LEXINGTON MISS		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME LAWRENCE JACKSON		13b. MOTHER'S MAIDEN NAME MARY ANN LYONS	
14. NAME OF HUSBAND OR WIFE L. LYONS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME _____	
17. ADDRESS _____		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 Month	
ANTECEDENT CAUSES DUE TO (b) Hypertension DUE TO (c) Arteriosclerotic Heart Disease		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) ST. LOUIS MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 200		22. I hereby certify that I attended the deceased from 5-24, 19 49, to 6-25, 1949, that I last saw the deceased alive on 6-25, 19 49, and that death occurred on 6-25, 1949, from the causes and on the date stated above.	
23a. SIGNATURE James J. Hedrick (Degree or title) _____		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 6-26-49		24. BURIAL, CREMATION, REMOVAL (Specify) _____	
24b. DATE 6-29-49		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK cem	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO		25. FUNERAL DIRECTOR'S SIGNATURE A. F. WATSON	
25. ADDRESS 2707 S TOODARD ST		DATE REC'D BY LOCAL REG. JUN 28 1949	
REGISTRAR'S SIGNATURE J. B. Lassiter		25. FUNERAL DIRECTOR'S SIGNATURE A. F. WATSON	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4049 St Germain

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.