

FILED AUG 2 1949

STANDARD CERTIFICATE OF DEATH

State File No. 25666

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1452

1. PLACE OF DEATH a. COUNTY ST. LOUIS COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LEMAY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JENNINGS	
c. LENGTH OF STAY (in this place) 1 1/2 YR		d. STREET ADDRESS (If rural, give location) 5409 HAMILTON	
d. FULL NAME OF HOSPITAL OR INSTITUTION MT. ST. ROSE HOSPITAL			

3. NAME OF DECEASED a. (First) BETTIE b. (Middle) MAE c. (Last) JACKSON			4. DATE OF DEATH (Month) (Day) (Year) JULY-11-1949		
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH JUNE-21-1924		9. AGE (in years last birthday) 25		IF UNDER 1 YEAR Months 0 Days 20	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) ST. LOUIS - MO	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME FRANCIS RUBAR		13b. MOTHER'S MAIDEN NAME JESSIE SOUTHARD		14. NAME OF HUSBAND OR WIFE JOHN JACKSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME John Jackson ADDRESS 5409 Hamilton Jennings - MO	

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, asthenia, etc. - It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral Far Advanced Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 1946-1949
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Tuberculosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)		

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from **April 1, 1949**, to **July 11, 1949**, that I last saw the deceased alive on **July 11, 1949**, and that death occurred at **1:30 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. M. Owen, M.D.		23b. ADDRESS 910 Broadway So.		23c. DATE SIGNED 7/11/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 7-14-49		24c. NAME OF CEMETERY OR CREMATORY FRIEDENS LEM	
24d. LOCATION (City, town, or county) (State) ST. LOUIS - MO					

DATE REC'D BY LOCAL REG. 7-13-49		REGISTRAR'S SIGNATURE Robert R. Alonzo, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS L. B. Tanner 6107 Natural Bridge	
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(Licensed Embalmer - Statement on Reverse Side)

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

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

J. W. M. Binkley

Licensed Embalmer No. *3653*

P. O. Address *St. Louis, Mo.*

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.