

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35257

318

1003

State File No. 8818

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town or TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 1416a Franklin Avenue			
3. NAME OF DECEASED (Type or Print) a. (First) Adam		b. (Middle)		c. (Last) Jackson		4. DATE OF DEATH (Month) (Day) (Year) Oct. 11 1949	
5. SEX Male 2		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 4, 1872	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Bessie Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME 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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH Undet. ANTECEDENT CAUSES DUE TO (b) Congestive Failure Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Metastasis - P. O. Carcinoma of Stomach with			
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) m.	
21d. TIME OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 157X			
22. I hereby certify that I attended the deceased from 10-3, 19 49, to 10-11, 19 49, that I last saw the deceased alive on 10-11, 19 49, and that death occurred at 6:20p m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. Sedrick D. ()				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 10-13-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-13-49		24c. NAME OF CEMETERY OR CREMATORY Leland,		24d. LOCATION (City, town, or county) (State) Miss.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 13 1949 J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE E. B. Kouse		ADDRESS 1221 N. Grand			

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 Clarence Brown

Licensed Embalmer No. 4755

P. O. Address.....

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.