

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21653

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5097**

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 Saint Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital # 1		c. LENGTH OF STAY (in this place) 3 1/2 Days	
		d. STREET ADDRESS (If rural, give location) 4807 Easton Avenue	

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) E.	c. (Last) Jackson	4. DATE OF DEATH (Month) (Day) (Year) June 9th, 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 13th, 1872	9. AGE (in years) (last birthday) 77	IF UNDER 1 YEAR Months 8 Days 26	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Saint Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Jackson	13b. MOTHER'S MAIDEN NAME Anna Martin	14. NAME OF HUSBAND OR WIFE Anna Jackson nee Kelly
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edward Jackson, 4807 Easton Avenue
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of the Prostate		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pericious Anemia		
	DUE TO (c)		
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"/>
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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)
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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? 177X
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **2:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Edward Jackson Deputy (Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 6/10/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/12/50	24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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DATE REC'D BY LOCAL REG. JUN 10 1950	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F. Feutz, 4828 Natural Bridge Blvd.
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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 _____

Ralph C. Zindler

Licensed Embalmer No. 4275

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.