

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31726

State File No.

8007

BIRTH NO. <u>52963-50</u>		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>8007</u>	
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 township) OR TOWN St. Louis				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Walter G. Phillips Hospital				d. STREET ADDRESS (If rural, give location) 2025 Carr			
3. NAME OF DECEASED (Type or Print)		a. (First) Bobbie		b. (Middle) Darnell		c. (Last) Jackson	
4. DATE OF DEATH (Month) (Day) (Year)		9		9		50	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/> WIDOWED		8. DATE OF BIRTH 9-4-50	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Ophelia Jackson	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <i>Rowland N. Whittier</i>	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Facial Paralysis Side, Rt. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 763D				22. I hereby certify that I attended the deceased from 9-4- , 19 50 to 9-8- , 19 50 , that I last saw the deceased alive on 9-8- , 1950, and that death occurred at 6:55p m. , from the causes and on the date stated above.	
23a. SIGNATURE <i>William J. Sibley</i>		(Degree or title) D. O.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 9-12-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) D		24b. DATE SEP 21 1950		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. SEP 21 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Services St. Louis 10, Mo.			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.