

FILED DEC 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12418

State File No.

10346

Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003**

I. 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) _____
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St Louis**
 d. FULL NAME OF HOSPITAL OR INSTITUTION **Homer G. Phelps**
 d. STREET ADDRESS (If rural, give location) **2229 2615 Clark**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 a. STATE **Missouri** b. COUNTY _____

3. NAME OF DECEASED
 a. (First) **GATEWOOD** b. (Middle) **J** c. (Last) **JACKSON**

4. DATE OF DEATH (Month) (Day) (Year)
11 29-50

5. SEX **Male** **6. COLOR OR RACE** **Col** **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)** **married**

8. DATE OF BIRTH **9-25-1907** **9. AGE** (In years last birthday) **43** **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Labor**

11. BIRTHPLACE (State or foreign country) **Oxford Miss.** **12. CITIZEN OF WHAT COUNTRY?** _____

13a. FATHER'S NAME **not known** **13b. MOTHER'S MAIDEN NAME** **Ella Bell** **14. NAME OF HUSBAND OR WIFE** **Rosie 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** **Rosie Jackson** **ADDRESS** **2615 Clark**

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
ANTECEDENT CAUSES
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (b) **Massive Intia Cerebral**
 DUE TO (c) **Neurorrhage: Cerebral**

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death. **Hypertension**

19a. DATE OF OPERATION _____ **19b. MAJOR FINDINGS OF OPERATION** _____ **20. AUTOPSY?** YES NO

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) _____ **21e. INJURY OCCURRED WHILE AT WORK** NOT WHILE AT WORK **21f. HOW DID INJURY OCCUR?** **331X**

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 _____, _____, from the causes and on the date stated above.

23a. SIGNATURE **3 Reg. (degree or title)** _____ **23b. ADDRESS** **1300 Clark** **23c. DATE SIGNED** **12/4/50**

24a. BURIAL, CREMATION REMOVAL (Specify) **Burial** **24b. DATE** **11-7-50** **24c. NAME OF CEMETERY OR CREMATORY** **Washington Park** **24d. LOCATION (City, town, or county) (State)** **St Louis County MO**

DATE REC'D BY LOCAL REG. **12-5** **REGISTRAR'S SIGNATURE** **J. Blaster** **25. FUNERAL DIRECTOR'S SIGNATURE** **AD Richardson** **ADDRESS** **2625 Glasgow**

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

Quint

A

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.....
Student Embalmer

Signed *AD Richardson*

Licensed Embalmer No. *2928*

P. O. Address *2625 Bluegrass*

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.