

FILED APR 9 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10233  
Registrar's No. 3004

BIRTH NO. 10322-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

6280

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

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. 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		2. STREET ADDRESS (If rural, give location) 3033 Thomas Street	
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) H.	
c. (Last) Jackson, Jr.		4. DATE OF DEATH (Month) (Day) (Year) Mar. 29 1951	
5. SEX Male ✓	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant 0	8. DATE OF BIRTH Jan. 31, 1951
9. AGE (In years last birthday) 1 28		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME John H. Jackson, Sr.	
13b. MOTHER'S MAIDEN NAME Carlean Payne		14. NAME OF HUSBAND OR WIFE --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME John H. Jackson, Sr.		ADDRESS 3033 Thomas St.	
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) <i>Lobar Pneumonia</i>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  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 checked="" type="checkbox"/> NO <input 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? H90X		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 6:55 A.M., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <i>Walter Randle</i>		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 3/30/51		24. NAME OF CEMETERY OR CREMATORY Washington Park	
24a. LOCATION (City, town, or county) St. Louis County		24b. (State) Mo.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 30 1951 <i>J. B. Foster</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. Randle & Son 3133 Bell Ave.	

**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 \_\_\_\_\_

*S. J. Watson*

Licensed Embalmer No. \_\_\_\_\_

*2698*

P. O. Address \_\_\_\_\_

*2769 Chouteau*

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.