

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24786  
6350

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED JUL 28 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).  
a. STATE **MO** b. 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** **2259**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Homer G Phillips Hospital**

3. STREET ADDRESS (If rural, give location) **1302 NO. 11<sup>th</sup> ST.**

3. NAME OF DECEASED  
a. (First) **Marion** b. (Middle) \_\_\_\_\_ c. (Last) **Jackson**

4. DATE OF DEATH (Month) (Day) (Year) **July 14 1951**

5. SEX **FEMALE**

6. COLOR OR RACE **NEGRO**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **WIDOWED**

8. DATE OF BIRTH **JAN. 25, 1896**

9. AGE (In years last birthday) **55** IF UNDER 1 YEAR Months \_\_\_\_\_ IF UNDER 12 HRS. Days \_\_\_\_\_ Mtn. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSEWIFE**

10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (State or foreign country) **COLDALE W. VA. /**

12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13a. FATHER'S NAME **JOE MITCHELL**

13b. MOTHER'S MAIDEN NAME **UNKNOWN**

14. NAME OF HUSBAND OR WIFE **UNKNOWN**

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. **NONE**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **JENNIE MITCHELL 1302 N. 11<sup>th</sup> 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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Hypertensive Heart Disease**  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) **Undetermined**  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death. **Cardio-vascular Disease**

INTERVAL BETWEEN ONSET AND DEATH  
**Undet.**

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) (Min) \_\_\_\_\_

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR **HH 3X**

22. I hereby certify that I attended the deceased from **7-9**, 19**51**, to **7-14**, 19**51**, that I last saw the deceased alive on **7-14**, 19**51**, and that death occurred at **6:30a m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Larue W. Harris M. D.**

23b. ADDRESS **2601 N Whittier St**

23c. DATE SIGNED **7-14-51**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL**

24b. DATE **7-18-51**

24c. NAME OF CEMETERY OR CREMATORY **WASHINGTON PK. CEM.**

24d. LOCATION (City, town, or county) (State) **BERKLEY MO**

DATE RECORDED BY CLERK **JUL 17 1951** REGISTRAR'S SIGNATURE **J. B. Foster**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **L. H. Bannister 3880 Easton Ave**

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

1291

**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

*Leroy W. Pannister*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4523

P. O. Address 3880 Easton Rd

**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.