

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35199**  
Registrar's No. **8701**

FILED OCT 23 1951

REG. DIST. NO. **318**

1008

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY-REG. DIST. NO. _____		Registrar's No. <b>8701</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis Mo.</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis 2239</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1 1515 Lafayette Ave.</b>				e. STREET ADDRESS (If rural, give location) <b>2618 Sidney St.</b>			
3. NAME OF DECEASED (Type or Print) <b>Joseph Jackson</b>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>October 2, 1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>January 1, 1871</b>		9. AGE (In years last birthday) <b>80</b>	10. UNDER 1 YEAR Days <b>9</b>	11. UNDER 2 HRS. Hours <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Packing House</b>		11. BIRTHPLACE (State or foreign country) <b>Belfast, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Thomas Jackson</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Lindsey</b>		14. NAME OF HUSBAND OR WIFE <b>Amelia Jackson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Amelia Jackson 2618 Sidney St.</b>			
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) <b>Chronic Myocarditis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Arterio sclerosis</b>  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 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? <b>H22R</b>			
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 <b>6:30 A</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>Patrick E. Taylor, Coroner</b> (Degree or title)				23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>10.2.51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>10/4/51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Evergreen, Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Chicago, ILL.</b>		
DATE REC'D BY LOCAL REG. <b>OCT 2 1951</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons 2630 Gravois Ave.</b>			

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

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**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

*Robert F. Gebken*

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

**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.