

FILED OCT 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35205
8689
Registrar's No. _____

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) 6yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4807 Easton Ave.		d. STREET ADDRESS (If rural, give location) 4807 Easton Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Sheridan c. (Last) Jackson			4. DATE OF DEATH (Month) (Day) (Year) Oct. 1 1951		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Nov. 15 1905		9. AGE (In years last birthday) 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME John E. Jackson	13b. MOTHER'S MAIDEN NAME Anne M. Kelty	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. 497-01-7180	17. INFORMANT'S SIGNATURE OR NAME Mrs. Anne Jackson, 4807 Easton	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH On day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary heart disease. 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 type="checkbox"/> NO <input type="checkbox"/>
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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? 4201

22. I hereby certify that I attended the deceased from _____, 19____, to 10-1-1951, that I last saw the deceased alive on 10-1-1951, and that death occurred at 5 p m., from the causes and on the date stated above.

23a. SIGNATURE Peter A. Ech M. H.	(Degree or title) 0	23b. ADDRESS 4701 St. Louis Ave.	23c. DATE SIGNED 10-2-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/3/51	24c. NAME OF CEMETERY OR CREMATORY St. Johns	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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DATE REC'D BY LOCAL REG. OCT 2 1951	REGISTRAR'S SIGNATURE J. Earl Smith M. H.	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral, 1905 Union Blvd.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Eck.
-4701a Eastern A
4701a St. Louis Ave.

(9:30 to 12)

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 *Warren A. Carver*

Licensed Embalmer No. *3534*

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.