

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10140**
Registrar's No. **2087**

MAR 24 1952
BIRTH NO.

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

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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 27 3226 Pine St.	
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) c. (Last) Jackson		4. DATE OF DEATH (Month) (Day) (Year) Feb. 29 1952	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH 4/8/ 1888
9. AGE (In years last birthday) 63		10. MONTHS 10	11. DAYS 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Boonville Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		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) Yes W. War I		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Magnolia Bohanan		ADDRESS 3226 a Pine 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Luetic Heart Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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"/>	
22. HOW DID INJURY OCCUR? 023X			
22. I hereby certify that I attended the deceased from 2-27 , 19 52 , to 2-29 , 19 52 , that I last saw the deceased alive on 2-29 , 19 52 and that death occurred at 4:05am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Laruse W Harris M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 2-29-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3/5/ 52	
24c. NAME OF CEMETERY OR CREMATORY National Cemetery		24d. LOCATION (City, town, or county) (State) Jeff. Bks., Mo.	
DATE REC'D BY LOCAL REG. MAR 4 1952		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Wm. Smith		ADDRESS Funeral H. 4019 Washington	

(Licensed Embalmer's Statement on Reverse Side)

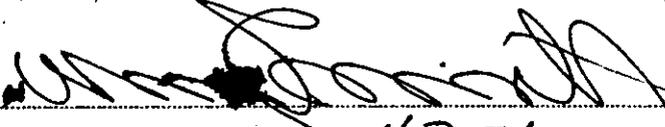
STATEMENT BY LICENSED EMBALMER

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  _____

Licensed Embalmer No. 4371 _____

P. O. Address St. Louis, Mo. _____

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.