S. No. 300
v. 10.48

MED OCT 1 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33070

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8571

1. PLACE OF DEATH
a. COUNTY St-Louis-Mo.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4317 Kennerly Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis. 2119
d. STREET ADDRESS (If rural, give location) 4317 Kennerly Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Gladys b. (Middle) c. (Last) Jackson

4. DATE OF DEATH (Month) Sept. (Day) 9th (Year) 1952

5. SEX Female 3
6. COLOR OR RACE Col.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Dec. 15. 1910.
9. AGE (In years last birthday) 41
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Janitor.
11. BIRTHPLACE (State or foreign country) Canton Miss. 1
12. CITIZEN OF WHAT COUNTRY? Yes

13a. FATHER'S NAME J.C. Wahes
13b. MOTHER'S MAIDEN NAME Lehia Wahes
14. NAME OF HUSBAND OR WIFE Clarence Jack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No.
16. SOCIAL SECURITY NO. 496-22-9053
17. INFORMANT'S SIGNATURE OR NAME Wilson Anderson ADDRESS 4317 Kennerly

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) Acute diffuse peritonitis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Contrib: Ruptured
DUE TO (c) Left tubo-ovarian abscess.

INTERVAL BETWEEN ONSET AND DEATH

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 ☐ 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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 624X

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 1:54 A m., from the causes and on the date stated above.*

23a. SIGNATURE Patrick J. Taylor 3 Coroner (Degree or title)
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 9/12/52

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal. 4
24b. DATE 9/15/52
24c. NAME OF CEMETERY OR CREMATORY Washington Park
24d. LOCATION (City, town, or county) St Louis County. (State)

DATE REC'D BY LOCAL REG. SEP 12 1952
REGISTRAR'S SIGNATURE J Carl Smith MD MJB
25. FUNERAL DIRECTOR'S SIGNATURE Herman J Smith ADDRESS 4247 Wabash Ave

(Licensed Embalmer's Statement on Reverse Side)

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

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 Arthur L. Hilliard

Signed.....
Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 4524 Aldine

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.