

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36141**  
Registrar's No. **9126**

**OCT 21 1952**

**318**

**1003**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

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</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place) <b>35 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>4549 Cote Brillante</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>		e. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Jessie</b>	b. (Middle)	c. (Last) <b>Atkins</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 29 1952</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>5/25/1886</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b>	IF UNDER 24 HRS. Hours <b>4</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Clarksville, Tenn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Robert Hamilton</b>	13b. MOTHER'S MAIDEN NAME <b>Betty Carter</b>	14. NAME OF HUSBAND OR WIFE <b>Garrett Atkins</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Garrett Atkins, 4549 Cote Brillante</b>	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 <b>Undet.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Peripheral Arteriosclerosis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Postoper. Mid thigh Open Amputation</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>Generalized Arteriosclerosis</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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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>4501</b>
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22. I hereby certify that I attended the deceased from **9-14**, 19 **52**, to **9-29**, 19 **52**, that I last saw the deceased alive on **9-29**, 19 **52**, and that death occurred at **9:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Edna E Brooks M.D.</b>	23b. ADDRESS <b>2601 N Whittier St</b>	23c. DATE SIGNED <b>9-30-52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10/4/52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem/</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>OCT 2 1952</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Gates, 4107 Finney Ave.</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
To Arkansas Bureau  
Sangene Ave.

**msb**

**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. 4259

P. O. Address 4107 Finney Avenue

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.