

FILED JAN 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2836

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 246

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MISSOURI Pacific Hospital</u>		Length of stay in 1b <u>12 1/2</u>	d. STREET ADDRESS (If outside, give location) <u>5039 KENSINGTON AVE.</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELINAH</u> Middle <u>JAMES</u> Last <u>JACKSON</u>		4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>57</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28, 1898</u>
9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DINING CAR WAITER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MISSOURI Pacific</u>	11. BIRTHPLACE (City and state or country) <u>Alexandria, La.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Abe Jackson</u>	
14. MOTHER'S MAIDEN NAME <u>Bessie Martin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Lillian Jackson (Wife) 5039 Kensington</u>	
18. CAUSE OF DEATH [Enter only one cause of death for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic H. Dis.</u> <u>Arteriosclerosis, genl.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, genl.</u> DUE TO (c) <u>Arteriosclerosis, genl.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>420.0</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>1-3-57</u> to <u>1-6-57</u> and last saw <u>him</u> alive on <u>1-6-57</u> Death occurred at <u>3:34</u> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <u>Charles James Jackson</u>		22b. ADDRESS <u>1755 S. Lincoln</u>	
22c. DATE SIGNED <u>1/7/57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>1-12-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Alexandria, La.</u>	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS <u>Charles J. Gates, 4107 Finney Ave.</u>	
25. DATE RECD. BY LOCAL REG. <u>JAN 9 57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

(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
Signature of Student Embalmer

Signed
Licensed Embalmer No. 187

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.