

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18852

FILED JUN 7 1957

Registration District No. 318 Primary Registration District No. 1003

STATE FILE NUMBER

Registrar's No. 4969

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in lb 39 years	STREET ADDRESS 2067 5045 Lotus		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Israel M. Jackson			4. DATE OF DEATH Month 5 Day 23 Year 57		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1891	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Terminal R. R.	11. BIRTHPLACE (City and state or country) Midway, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Jackson			14. MOTHER'S MAIDEN NAME Nannie Sanchez		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Suella Jackson, 5045 Lotus		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal Varices, Bleeding					INTERVAL BETWEEN ONSET AND DEATH 23 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) _____					
DUE TO (c) _____					
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4621					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 a. m. p. m. Month, Day, Year					
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 5-22-57 10:10AM to 5-23-57 and last saw him ^{her} alive on 5-23-57 Death occurred at 9:06 p. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Frank J. Richards, M.D.</i> (Degree or title)			22b. ADDRESS 2601 N. Whittier St.		22c. DATE SIGNED 5-21-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/28/57	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Charles J. Gates, ADDRESS 4107 Finney Ave.		25. DATE RECD. BY LOCAL REG. MAY 27 '57	26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i> <i>mgs</i>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. 458

P. O. Address 4107 Finns

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.