

THE DIVISION OF HEALTH OF MISSOURI

FILED JUN 20 1957

STANDARD CERTIFICATE OF DEATH

State File No. 57.022605

No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 5500
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____		
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3 mo.	c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 2227 1/2 2035 Eugenia St.		
3. NAME OF DECEASED (Type or Print) a. (First) Elmer b. (Middle) _____ c. (Last) Jackson		4. DATE OF DEATH (Month) (Day) (Year) June 1 1957		
5. SEX male	6. COLOR OR RACE colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH 8-10-1872	9. AGE (In years last birthday) 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME James Jackson		
13b. MOTHER'S MAIDEN NAME Martha Griffin		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Hospital Records
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Baenohyguemoma INTERVAL BETWEEN ONSET AND DEATH 3 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 491x		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis		19a. DATE OF OPERATION 9/24/56		
19b. MAJOR FINDINGS OF OPERATION Cystolithiasis & Benign Prostatic Hypertrophy		20. AUTOPSY? 2		
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"/>		21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from Jan. 2, 1957 , to June 1, 1957 , that I last saw the deceased alive on June 1, 1957 , and that death occurred at 11:05 P.m. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.		23b. ADDRESS 5800 Arsenal		23c. DATE SIGNED 6/3/57
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 6-29-57		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service		
DATE REC'D BY LOCAL REG. JUN 13 57		REGISTRAR'S SIGNATURE Carl Smith M.D.		ADDRESS 410 1/2 Manchester Ave. St. Louis 10, Mo.

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

St. J.

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.....

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.