

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH29592  
STATE FILE NUMBER

318

1003

6935

Registration District No. Primary Registration District No. Registrar

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutions: 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 type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in <input type="checkbox"/>	d. STREET ADDRESS 1230 Blackstone (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Will Jackson			4. DATE OF DEATH Month Day Year 7 22 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 Oct. ? 1891
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		9b. KIND OF BUSINESS OR INDUSTRY Emerson Electric	9c. BIRTHPLACE (City and state or country) Arberdean, Miss.
10. FATHER'S NAME Andrew Jackson		11. MOTHER'S MAIDEN NAME unknown	
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		13. SOCIAL SECURITY NO. 486-16-1148	14. INFORMANT Emma Jackson 1230 Blackstone
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency DUE TO (b) Myocardial Infarction DUE TO (c) Coronary Thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis - Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH undet.
16a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		16b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
17a. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		17b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
18a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		18b. CITY, TOWN, OR LOCATION COUNTY STATE	
19. I attended the deceased from 7-12-57 to 7-22-57 and last saw <sup>YANK</sup> him alive on 7-22-57 Death occurred at 12:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
20a. SIGNATURE Hugh Waters, M.D.		20b. ADDRESS 2601 Whittier Street	
21a. BURIAL, CREMATION, OR REMOVAL (Specify) removal		21b. DATE 7-27-57	21c. NAME OF CEMETERY OR CREMATORY Washington Park
22a. FUNERAL DIRECTOR Rennie F. Home		22b. ADDRESS 215 So. Jeff	22c. DATE RECD. BY LOCAL REG. JUL 24 57
23a. LOCATION (City, town, or county) St. Louis, Co., Mo.		23b. REGISTRAR'S SIGNATURE Earl Smith MO	

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Arthur L. Hillier*

Licensed Embalmer No. *42*

P. O. Address *3100 Co*

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.