

Health, Welfare, Public Service

100 0

1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL DISEASES IN PART I MUST BE CAUSALLY RELATED

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33673

STATE FILE NUMBER

FILED SEP 30 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 8742

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		c. CITY OR TOWN <u>South Kinloch</u> <u>4091</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>Saint Louis Maternity</u>		d. STREET ADDRESS (If outside, give location) <u>980 Fifth Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jackson</u>		4. DATE OF DEATH Month Day Year <u>September 9 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>September 9 1957</u>
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (City and state or country) <u>St Louis Missouri</u>
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? ---	
13a. FATHER'S NAME <u>Fierce Jackson</u>		13b. MOTHER'S MAIDEN NAME <u>Betty Louise Lucius</u>	
14. NAME OF HUSBAND OR WIFE ---		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---	
16. SOCIAL SECURITY NO. ---		17. INFORMANT <u>Betty Louise Jackson</u> Address <u>Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Omphalocoele</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____			<u>5602</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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>September 9 1957</u> to <u>September 9, 57</u> and last saw her/him alive on <u>September 9 1957</u> Death occurred at <u>3:45 P M</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Thomas K. Meschery M.D.</u> (Degree & title)		22b. ADDRESS <u>St. L. Maternity Hospital</u>	
22c. DATE SIGNED <u>9-12-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>9-30-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		24. FUNERAL DIRECTOR <u>Rowland Akew 4104 Manchester</u> ADDRESS	
25. DATE RECD. BY LOCAL REG. <u>SEP 18 57</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Smith</u>	

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.**