Health, Welfare Public Service

300
-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003726
STATE FILE NUMBER

FILED FEB 11 1959

Local Registration District No. 317 Primary Registration District No. 541 Registrar's No. 249

1. PLACE OF DEATH
a. COUNTY: ST. LOUIS
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): CLAYTON St. Louis County — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): County Hospital — Length of stay in 1b: 7 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: WELLSTON 4301 — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 6150 Minerva — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Sally Middle: Last: Jackson

4. DATE OF DEATH: Month 1 Day 21 Year 1959

5. SEX: F 3

6. COLOR OR RACE: Col.

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ 2 **DIVORCED** ☐

8. DATE OF BIRTH: 2-3-84

9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Fayette, Mo. 0

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Ed Diggs

13b. MOTHER'S MAIDEN NAME: Ellen Williams

14. NAME OF HUSBAND OR WIFE: unk.

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.: 498-34-6638

17. INFORMANT: Harden Burton — Address: 6150 Minerva

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): GENERALIZED ARTERIOSCLEROSIS.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ No

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 ☐ NOT WHILE AT WORK ☐

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 1-15-1959, to 1-21-1959 and last saw her/him alive on 1-21-1959
Death occurred at 6.10 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H. B. Bailey (Degree or title): M.D. 0

22b. ADDRESS: 601 S. Brentwood, Clayton Mo.

22c. DATE SIGNED: 1-21-1959

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 1-27-59

23c. NAME OF CEMETERY OR CREMATORY: Greenwood

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: A.L. Beal — **ADDRESS**: Und.-Co.-4303 Delmar

25. DATE RECD. BY LOCAL REG.: 1-27-59

26. REGISTRAR'S SIGNATURE: John C. Murphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 U. D. Richardson

Licensed Embalmer No. 3428

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.