

FILED MAR 13 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007259  
STATE FILE NUMBER  
2 1679

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Infirmary</u>		Length of stay in lb <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>915 Bond</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACKSON</u>			4. DATE OF DEATH Month Day Year <u>FEB. 14 1959</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 type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 14, 1959</u>
9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. <u>1 40</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>
11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>---</u>	
13a. FATHER'S NAME <u>Alphonzo Jackson</u>		13b. MOTHER'S MAIDEN NAME <u>BARBARA ANN Howard</u>	
14. NAME OF HUSBAND OR WIFE <u>---</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Ms Barbara Jackson</u> Address <u>915 Bond Ave E. St. Louis Mo</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>Prematurity, Massive abdominal hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>771.5</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>---</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>---</u>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>---</u>	
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.) <u>---</u>	
20f. CITY, TOWN, OR LOCATION <u>---</u>		COUNTY STATE <u>---</u>	
21. I attended the deceased from <u>4:05 pm 2-14-59</u> to <u>6:45 pm 2-14-59</u> and last saw her alive on <u>2-14-59</u> Death occurred at <u>5:45 pm</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M<sup>c</sup> Kinely W. Egan, M.D.</u> (Degree or title)		22b. ADDRESS <u>1536 Papine</u>	
22c. DATE SIGNED <u>2-15-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>2/17/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Charles J. Gates</u> ADDRESS <u>4107 Finney</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 17 '59</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>		27. <u>---</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Guylton Swan* .....

Licensed Embalmer No. 4580 .....

P. O. Address 4107 Finney Av .....

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.