

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011046
STATE FILE NUMBER
2143

FILED MAR 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57

113

891
0

due to epilepsy

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Quercif.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Frisco Hospital		d. STREET ADDRESS (If outside, give location) 4231 Blaine Ave.	

3. NAME OF DECEASED (Type or print) First Middle Last ALEXANDER JACQUIN			4. DATE OF DEATH Month Day Year Feb. 28 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1905	9. AGE (In years less birthday) 54	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician-Frisco	10b. KIND OF BUSINESS OR INDUSTRY R.R.Co.	11. BIRTHPLACE (City and state or country) Chicago, Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Alexander Jacquin	13b. MOTHER'S MAIDEN NAME Delores Smith	14. NAME OF HUSBAND OR WIFE Opal Jacquin
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None	16. SOCIAL SECURITY NO. 702-07-4979	17. INFORMANT Opal Jacquin	Address 4231 Blaine Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Skull fractures with subdural subarachnoid and intracerebral hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) 353.3	
	DUE TO (c)	
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? 1 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. PLACE OF INJURY (e.g., in or about home, farm, city street, office bldg., etc.) 124 Hosp St Louis Mo		20c. TIME OF INJURY Hour Month, Day, Year a.m. 2 24 59 p.m.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at _____ 7:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ralph M. Jensen	(Degree or title) R3	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 3/2/59
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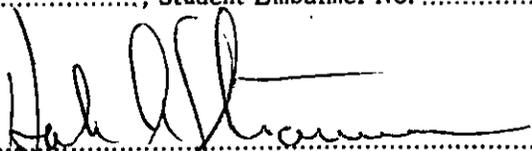
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar. 3, 1959	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Kriegshauser 4228 S.Kingshighway	25. DATE RECD. BY LOCAL REG. MAR 2 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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. 4533

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.