

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015168

STATE FILE NUMBER

FILED MAY 6 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar **2 3733**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hamilton Nursing Home-3 Wks.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>2045 Geyer</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ANABEL</b> Middle <b>JACKSON</b> Last			4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1909</b>	9. AGE (In years last birthday) <b>49</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Carroll Co., Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Thomas Younger</b>		13b. MOTHER'S MAIDEN NAME <b>Ethel Goodrum</b>		14. NAME OF HUSBAND OR WIFE <b>Arvil Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Arvil Jackson, 2045 Geyer, St. Louis</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary edema</b> <b>metastases from breast cancer</b> DUE TO (b) <b>METASTASES FROM BREAST CANCER 8 MONTHS</b> DUE TO (c) <b>CANCER OF RIGHT BREAST.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>170 X</b>		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 _____ a.m. _____ p.m.	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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <b>SEPT., 1958</b> to <b>April 14, 1959</b> and last saw <input checked="" type="checkbox"/> alive on <b>April 14, 1959</b> Death occurred at <b>8:10 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>W. R. Magee, M.D.</b> (Degree or title)	22b. ADDRESS <b>4952 Maryland St. Mo.</b>	22c. DATE SIGNED <b>4/14/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-17-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b>
23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b>		(State)

24. FUNERAL DIRECTOR <b>McLaughlin Funeral Home, Inc.</b> ADDRESS <b>2301 Lafayette, St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>APR 15 '59</b>	26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

DR. MAHEE  
4952 MARYLAND

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 *James R. Chapman* .....

Licensed Embalmer No. *4559* .....

P. O. Address *St. Louis* .....

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.