

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015173

STATE FILE NUMBER

3278

FILED APR 20 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. 3278

300  
1-57  
20  
293  
0

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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>Saint Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Saint 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>3 4570 Page Blvd.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>4912 Maple Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rosa Jackson</b>			4. DATE OF DEATH Month Day Year <b>March 29, 1959</b>		
5. SEX <b>Female 3</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1891</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>68</b> Months Days Hours Min.
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	11. BIRTHPLACE (City and state or country) <b>Turner, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Napoli Lane</b>		13b. MOTHER'S MAIDEN NAME <b>Fannie Cotton</b>		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) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>Freddie H. Jackson 4912 Maple Ave.</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>Acute Congestive Heart Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertensive Heart Disease</b> DUE TO (c) <b>Hypertension, Essential. 443X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>Undetermined</b>
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.)			
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 <b>Jan. 1956</b> to <b>March 1959</b> and last saw her alive on <b>March 29, 1959</b> Death occurred at <b>11:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>J. Newton Jenkins M.D.</b>			22b. ADDRESS <b>3507 Franklin Ave. St. Louis Mo.</b>		22c. DATE SIGNED <b>4-1-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipped</b>		23b. DATE <b>4-1-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Helena, Arkansas</b>		23d. LOCATION (City, town, or county) (State) <b>West Helena Arkansas</b>
24. FUNERAL DIRECTOR ADDRESS <b>Metropolitan Funeral System, Inc. 5010 Enright</b>		25. DATE RECD. BY LOCAL REG. <b>APR 1 '59</b>		26. REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b> <i>m j b.</i>	

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 *John K. Cunningham* .....

Licensed Embalmer No. *4476* .....

P. O. Address *2405 ...* .....

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.