

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019289

STATE FILE NUMBER

FILED JUN 11 1959

Registration District No.

Primary Registration District No.

Registrar No.

5187

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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 Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3028 Madison	

3. NAME OF DECEASED (Type or print) First Willie Middle Mae Last Jarrett			4. DATE OF DEATH Month 5 Day 26 Year 59		
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/1906	9. AGE (In years last birthday) 52	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Forest City, ARK.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charlie Whitefield	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE OSCAR M. JARRETT
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address OSCAR JARRETT, 3028 MADISON
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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) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis		
DUE TO (c) 331*		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive vascular disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from 5-13-59 to 5-26-59 and last saw her alive on 5-26-59 Death occurred at 6:20 P on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE A. D. Inash (Degree or title) , M.D.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 5-28-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/1/59	23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON	23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.
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24. FUNERAL DIRECTOR W. ROBINSON & SONS: 2721 CASS	25. DATE RECD. BY LOCAL REG. MAY 29 '59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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Health, Welfare, Public Service

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

doctor, coroner, etc. must use only statements

md

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 *Leroy H. Darnie*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.