

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023077
STATE FILE NUMBER
Registration No. 5795

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **ST. LOUIS, MO.** Inside Limits Yes No

c. CITY OR TOWN **ST. LOUIS, MO.** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **ST. LOUIS CITY HOSP. #1.** Length of stay in 1b

d. STREET ADDRESS (If outside, give location) **2806 Washington Ave.** Reside on Farm

3. NAME OF DECEASED First Middle Last
(Type or print) **JACKSON KERCHIVAL**

4. DATE OF DEATH Month Day Year
MAY 18, 1959

5. SEX **MALE**

6. COLOR OR RACE **NEGRO**

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH **11-7-84**

9. AGE (In years and day) **74** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **none**

10b. KIND OF BUSINESS OR INDUSTRY **none**

11. BIRTHPLACE (City and state or country) **FLA.**

12. CITIZEN OF WHAT COUNTRY? **??**

13a. FATHER'S NAME **HORACE KERCHIVAL**

13b. MOTHER'S MAIDEN NAME **EMMA (Unknown)**

14. NAME OF HUSBAND OR WIFE **Unknown**

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 **ST. LOUIS CITY HOSP. #1.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Coronary occlusion**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **420.1**
DUE TO (c) _____
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

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 **4/11/59** to **5/18/59** and last saw her/him alive on **5/18/59**
Death occurred at **2:15 P** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Rowland Aker M.D.**

22b. ADDRESS **1515 LAFAYETTE AVE**

22c. DATE SIGNED **5/19/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **6-30-1959**

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY **Anatomical Board**

23d. LOCATION (City, to what county) (State) **St. Louis, Mo.**

24. FUNERAL DIRECTOR **Rowland Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.**

25. DATE RECD. BY LOCAL REG. **JUN 18 '59**

26. REGISTRAR'S SIGNATURE **Rowland Smith, M.D. M.P.H.**

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
MEDICAL CERTIFICATION

S. 300
v. 1-57
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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.....

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.