

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
 FILED VS NOV 20 1959

**59-042024**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **10260**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS MO</b>	Length of stay in 1b <b>3 WKS.</b>	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>2601 GURNEY CT</b>		d. STREET ADDRESS (If outside, give location) <b>2601 GURNEY</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LOUISE</b> Last <b>JACKSON</b>			4. DATE OF DEATH Month <b>11</b> - Day <b>8</b> - Year <b>59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</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>6-23-1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MGR. BOOK STORE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BOOK BUSINESS</b>		11. BIRTHPLACE (City and state or country) <b>ASHTABULA, OHIO</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>JOHN SEXTON</b>		13b. MOTHER'S MAIDEN NAME <b>?</b>		14. NAME OF HUSBAND OR WIFE <b>JOHN 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. <b>023-03-5584</b>		17. INFORMANT Address <b>DR. RICHARD W. JACKSON 2601 GURNEY</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>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10/30/59 +</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <b>420.0</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.	Month, Day, Year _____		

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>10/30/59</b> to <b>11/8/59</b> and last saw her <b>alive</b> on <b>11/8/59</b> Death occurred at <b>11:30</b> <b>PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Bernard F. King MD</b>	(Degree or title)	22b. ADDRESS <b>Sh. Louis 16. Mo</b>	22c. DATE SIGNED <b>11/11/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE <b>11-9-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MISSOURI CREMATORY</b>	23d. LOCATION (City, town, or county) <b>ST. LOUIS, MO.</b>
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24. FUNERAL DIRECTOR <b>HOWARD H. MICHEL 5930 SOUTHWEST</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>NOV 9 1959</b>	26. REGISTRAR'S SIGNATURE <b>Keal Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Prof. Embalmed - Handwritten

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.