

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 5 9 5

FILED VS JAN - 4 1960

211610

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST LOUIS CITY HOSP # 1		d. STREET ADDRESS (If outside, give location) 2525a Salisbury St.	
3. NAME OF DECEASED (Type or print) First Middle Last MARK JACKSON		4. DATE OF DEATH Month Day Year 12 13 1959	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/21/1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Screw Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 49
11. BIRTHPLACE (City and state or country) Jackson, Mississippi		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME John Wesley Jackson		13b. MOTHER'S MAIDEN NAME Mary Leadingham	
14. NAME OF HUSBAND OR WIFE None		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. 525-07-0477		17. INFORMANT Address Mrs. Norman Triefenback	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1) Obstructive Emphysema, none. 2) Chronic Cor pulmonale, 3) Chron. congestive heart failure, Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4 DUE TO (c) 3			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5271			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour a.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 12/8/59 to 12/13/59 and last saw her alive on 12/13/59 Death occurred at 8:15 P on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. Leightner		22b. ADDRESS 1515 LAFAYETTE AVE.	
22c. DATE SIGNED 12/13/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 12/19/1959	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) (State) Hanley Hills, Mo.
24. FUNERAL DIRECTOR ADDRESS Morrell Mortuary 3710 North Grand		25. DATE RECD. BY LOCAL REG. DEC 15 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lorou E. Percy

Licensed Embalmer No. 4094

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.