

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003594

FILED VS JAN 22 1960

2 205

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Incarinate Word Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2226 Keokuk</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>D.</u> Last <u>Jackson</u>	4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1960</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/1898</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Steel & Hibbard Lum.</u>	11. BIRTHPLACE (City and state or country) <u>Kennett, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Chalres Jackson</u>	13b. MOTHER'S MAIDEN NAME <u>Lula (Unk.)</u>	14. NAME OF HUSBAND OR WIFE <u>Lola</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>488 09 7526</u>	17. INFORMANT Address <u>Lola Jackson 2226 Keokuk St. Louis, Mo.</u>
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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) <u>Left cerebral infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-1-60</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Thrombosis left anterior Carotid artery</u>	<u>1-1-60</u>
	DUE TO (c) <u>arteriosclerosis 332x unclerated</u>	<u>duration</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Terminal Pneumonia (2 day)</u>	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
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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 8-27-57 to 1-6-60 and last saw her alive on 1-6-60
Death occurred at 12:30 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John T Flynn BS MD</u>	22b. ADDRESS <u>1715 So 39th, St Louis Mo</u>	22c. DATE SIGNED <u>1-7-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 11, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Trinity Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lemay, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>C. Hoffmeister Mortuaries 7814 So. Broadway St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 7 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u>
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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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Denne

Licensed Embalmer No. 419
P. O. Address St. Louis

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.