

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS FEB 23 1960**

**-60-008404**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 1687** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3635<sup>th</sup> PAGE BLVD</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3635<sup>th</sup> PAGE BLVD</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>TILLIE</b> Middle <b>JACKSON</b> Last				4. DATE OF DEATH Month <b>2</b> Day <b>10</b> Year <b>60</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>colored</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-22-94</b>		9. AGE (last birthday) <b>65 YRS</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>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>					
13a. FATHER'S NAME <b>HENRY F. JONES</b>				13b. MOTHER'S MAIDEN NAME <b>VICTORIA CYNTHIA</b>				14. NAME OF HUSBAND OR WIFE <b>ROBERT JACKSON</b>					
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 <b>VIOLA THOMPSON</b>		Address <b>1719 N. ELLIOTT</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>hypertensive cardiovascular disease</b> <b>arteriosclerosis</b> <b>under-performed</b> 443X. CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 M.S.</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					
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 checked="" 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>Feb. 1 - 1959</b> to <b>Feb. 7 - 1960</b> and last saw her/him alive on <b>2-7-60</b> Death occurred at <b>2-10-60 2-10-60</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>G.B. Key</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>#4 So. Compton</b>				22c. DATE SIGNED <b>2-11-60</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>2-16-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD CEM.</b>				23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS CTY MO</b>					
24. FUNERAL DIRECTOR <b>A.F. WALTON</b> ADDRESS <b>2707 Stoddard</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 13 1960</b>		26. REGISTRAR'S SIGNATURE <b>Karl Smith M.D.</b>							

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 *W. C. Claude, Jr.*

Licensed Embalmer No. 346

P. O. Address 1123 9th

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