

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029226

FILED VS JUL 22 1960

317

Primary Registration District No. 500

Registrar's No. 1961

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>St. Louis</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marlboro</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7925 Martys Dr.</b>		Length of stay in 1b <b>2 Yrs.</b>		c. CITY OR TOWN <b>Marlboro</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7925 Martys Dr.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Month Day Year	
First <b>CARRIE</b>		Middle <b>B.</b>		Last <b>JACKSON</b>		<b>June 25 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>12-13-1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Centralia, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown Anthony</b>			14. NAME OF HUSBAND OR WIFE <b>William W. 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>None</b>		17. INFORMANT Address <b>William W. Jackson 7925 Martys Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Unknown Natural Cause</b>							
Conditions, if any, which gave rise to above cause - (a), stating the underlying cause last.							
DUE TO (b) _____							
DUE TO (c) _____							
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 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 _____, to _____ and last saw her/him alive on _____ Death occurred at <b>7:00 A.</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Or see or file) <b>John C. Murphy Md Assn Health Commissioner</b>				22b. ADDRESS <b>801 S. Brentwood Clayton, Mo.</b>		22c. DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 28, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>6-27-60</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy Md Assn</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 R. W. Storrans

Licensed Embalmer No. 4007

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.