

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4000 Finney	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Louis Middle Last Jackson			4. DATE OF DEATH Month 11 Day 10 Year 60		
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan 12, 1877	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Tenn	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME Pleas Jackson	13b. MOTHER'S MAIDEN NAME Mary Ann ?	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
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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) no	16. SOCIAL SECURITY NO.	17. INFORMANT Louis Jackson Feet & Fee & Hall	Address
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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) Chronic Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH Undet.
DUE TO (b)		
DUE TO (c) 6000		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Thrombosis		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 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.)
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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 10-28-60 to 11-10-60 and last saw <input checked="" type="checkbox"/> him alive on 11-10-60	
Death occurred at 6:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) Sydney A. Mason, M. E.	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 11-10-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-15-60	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem	23d. LOCATION (City, town, or county) (State) St. Louis
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24. FUNERAL DIRECTOR Mutual Security Undertaker	ADDRESS 705 Chestnut	25. DATE RECD. BY LOCAL REG. NOV 12 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Palmer

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.