

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008248  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1629

FILED FEB 16 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived.)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>   |   | Length of stay in lb  | c. CITY OR TOWN<br><u>St. Louis</u>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Missouri Baptist Hospital</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>6210 Wagner</u>   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Kenneth</u> Middle <u>Jay</u> Last <u>Jackson</u>  |   | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>20</u> Year <u>1962</u>   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-20-62</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (last birthday)<br><u>1 hr. &amp; 15m.</u>   |
| 11. BIRTHPLACE (City and state or country)<br><u>Missouri</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |   |
| 13a. FATHER'S NAME<br><u>Albert James Jackson</u>   |   | 13b. MOTHER'S MAIDEN NAME<br><u>Leatha Marie Jackson</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><u>Hospital Records</u>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atelectasis &amp; Pulmonary Failure</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Aspirated Meconium</u><br>DUE TO (c) <u>762.0</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr. 10 min.</u>  |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <u>1/20/62</u> to <u>1/20/62</u> and last saw him alive on <u>1/20/62</u><br>Death occurred at <u>12:40</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |   |
| 22a. SIGNATURE<br><u>Joseph F. Trigg, M.D.</u>  |   | 22b. ADDRESS<br><u>7165 Delmar, 30</u>  |   |
| 22c. DATE SIGNED<br><u>1/26/62</u>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><u>2-28-62</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Anatomical Board</u>   | 23d. LOCATION (City, town, or county)<br><u>St. Louis, Mo.</u>  |
| 24. FUNERAL DIRECTOR<br><u>Rowland Mortuary Svc. 4104-06 Manchester</u>   |   | 25. DATE RECD. BY LOCAL REG.<br><u>FEB 8 1962</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Loed Smith, M.D.</u>  |

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.