

S. No. 2
M-8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 33123
Registrar's No. 8882

FILED OCT 4 1947
Registration District No. 818

Primary Registration District No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. MARY'S INFIRMARY
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILL. (b) County ST. CLAIR
(c) City or town E. ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 915 CUTTER AVE.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JACKIE WASHINGTON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUGUST 4 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
— 1 16 hr. — min.

9. Birthplace E. ST. LOUIS ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name CHARLES WASHINGTON

13. Birthplace WATER VALLEY MISS.
(City, town, or county) (State or foreign country)

14. Maiden name MINNIE L. WASHINGTON

15. Birthplace CAMPDEN ARK.
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Washington

(b) Address 915 Cutter Ave.

17. (a) E. ST. LOUIS, ILL. (b) Date thereof SEPT. 29, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BOOKER WASHINGTON

18. (a) Signature of funeral director P. D. Craggler

(b) Address 1036 T. U. PARK AVE., E. ST. LOUIS, MO.

19. (a) SEP 22 1947 (b) J. F. Pinedeck
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9/20/47 day _____
year _____ hour 10 minute 25 P M.

21. I hereby certify that I attended the deceased from 9/19/47 to 9/20/47, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 24 hrs

Due to Not known

Due to _____

Other conditions 83
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Cerebral Hemorrhage

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. H. Roberts (M. D. or other) MD
Address 121 Kansas Date signed 9/22/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Not embalmed.

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 this body is not embalmed, fact should be so stated above.