

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10925

STATE FILE NUMBER

2822

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.				Length of stay in 20 days		d. STREET ADDRESS 4939 Nottingham	
3. NAME OF DECEASED (Type or print) First MARY Middle VIRGINIA Last RAVENS CROFT				4. DATE OF DEATH Month MAR. Day 20, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1871		9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Gilmore				14. MOTHER'S MAIDEN NAME Harriett Jackson			
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. None		17. INFORMANT Address Mrs. Opal Walsh, 5041 Waterman			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bronchial Pneumonia							
DUE TO (c) Senility & malnutrition							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Calculi							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.) 332x				
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	
21. I attended the deceased from 2-128/57 to 3/20/57 and last saw her alive on 31-20/57 Death occurred at 11:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE N.A. Kabalin, M.D.				22b. ADDRESS 1515 LARAYETTE AVE.		22c. DATE SIGNED 3/2 1/57.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-23-57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. MAR 22 '57		26. REGISTRAR'S SIGNATURE Carl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

m76

Health,
Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Name of Deceased: *John S. Jackson*
 Sex: *Male*
 Race: *White*
 Date of Death: *March 1, 1871*
 Age at Death: *28*
 Cause of Death: *None*
 Residence: *St. Louis, Mo.*
 Place of Burial: *St. Louis, Mo.*
 Name of Undertaker: *Harriet Jackson*
 Name of Embalmer: *John S. Jackson*

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 *John S. Jackson*
 Licensed Embalmer No. *419*

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.