

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019284

STATE FILE NUMBER

FILED JUN 4 1959

Registration District No. Primary Registration District No.

Registrar 2 5083

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	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2918 Montgomery	
3. NAME OF DECEASED (Type or print) First Alberta Middle Last Jackson		4. DATE OF DEATH Month 5 Day 22 Year 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laudress		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 50 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
11. BIRTHPLACE (City and state or country) Macon, Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Norman Adams		13b. MOTHER'S MAIDEN NAME Louisa Lewis	14. NAME OF HUSBAND OR WIFE George 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. 425-50-3214	17. INFORMANT Address George Jackson 2918 Montgomery Avenue
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 THROMBOSIS 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) HYPERTENSIVE CARDIOVASCULAR DISEASE.			INTERVAL BETWEEN ONSET AND DEATH Undet. 332x
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <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 4-24-59 , to 5-22-59 and last saw her/him alive on 5-22-59 Death occurred at 10-50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul G. Larson, M. D.		22b. ADDRESS 2601 N. Whittier	
22c. DATE SIGNED 5-23-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/28/59	
23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		23d. LOCATION (City, town, or county) (State) Lemay, Missouri	
24. FUNERAL DIRECTOR ADDRESS E. B. Kionce 1221 N. Grand Blvd.		25. DATE RECD. BY LOCAL REG. MAY 26 '59	
26. REGISTRAR'S SIGNATURE Heard Smith, M. D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Clarence J. [unclear]*

Licensed Embalmer No. *755*
P. O. Address *1221 N. 4th*

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.