

REC'D OCT 19 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

31999  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Clay Registration District No. 201  
 (b) Township Liberty Primary Registration District No. 5280  
 (c) City Liberty (d) Street No. \_\_\_\_\_ Registered No. 79  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME George S. Jackson  
 (a) Residence, No. 1004 Woburn St. Mo  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 7 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 8 7

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 22 1938

22. I HEREBY CERTIFY That I attended deceased from Sept 1 to Sept 22, 1938  
 I last saw him alive on Sept 21, 1938. Death is said to have occurred on the date stated above, at 8 A. m.  
 The principal cause of death and related causes of importance were as follows:  
Senility  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: 162

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) A. H. Mansfield, M. D.  
1938 (Address) Liberty Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Troy Missouri

FATHER 13. NAME William A Jackson  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo Kentucky

MOTHER 15. MAIDEN NAME Anna M. Jackson  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo Missouri

17. INFORMANT (ADDRESS) J. P. O. Home Liberty Missouri

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE South Troy Mo DATE 9/23 1938

19. FUNERAL DIRECTOR (ADDRESS) Butcher + Sponger Liberty Missouri

20. FILED 9/27 1938 E. T. Brant  
 Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X12004

EXHIBIT EX-101-11-11-11

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 10/12/88

STATEMENT BY LICENSED EMBALMER

I, Victor E. Luningger, Licensed Embalmer No. 2896  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself  
L. E.  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.  
Signed Victor E. Luningger  
Licensed Embalmer No. \_\_\_\_\_

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.)



