

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.

OCT 18 1939

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

33773
Do not use this space.

1. PLACE OF DEATH

(a) County Nevada Registration District No. 875
 (b) Township Washington Primary Registration District No. 6162
 (c) City Alexander (d) Street No. State Hospital #3 Registered No. 238
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred — yrs. — mos. 4 ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Lee Joseph Jackson
 (a) Residence, No. 250 St. Greenfield, 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 W 4. COLOR OR RACE M 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ?
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ?
 7. AGE YEARS 74 MONTHS 1 DAYS ? If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as Sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. Farming
 10. Date deceased last worked at this occupation (month and year) ? 11. Total time (years) spent in this occupation ?

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

FATHER 13. NAME ? 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

MOTHER 15. MAIDEN NAME ? 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

17. INFORMANT (ADDRESS) Records, State Hospital #3

18. BURIAL, CREMATION, OR REMOVAL PLACE Ninden, Mo DATE Sept. 12, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gray Funeral Home, Nevada, Mo.

20. FILED Sept 12, 1939 Allen D. Hays Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1939, to Sept. 12, 1939
 I last saw him alive on Sept. 12, 1939 Death is said to have occurred on the date stated above, at 11:20 a.m.
 The principal cause of death and related causes of importance were as follows:

Degenerative Heart Disease - fibrillation

Date of onset

Other contributory causes of importance:

Myocardial Exhaustion
Senility

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

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? No
 If so, specify _____

(Signed) D. H. Potter, M. D.
 (Address) Nevada, Mo.

RECEIVED

District Health Officer No. 7,

District File Number 7-39-1449

Date Filed 10-11-39

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 M E Feun

Licensed Embalmer No. 1432

P. O. Address Nevada, N

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, above space should be left blank.