

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

MO. I 19151

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 657

Primary Registration District No. 4388

Registrar's No. 48

1. PLACE OF DEATH: Remised
 (a) County Remised
 (b) City or town Carthageville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location) 2
 (d) Length of stay: In hospital or institution. _____ (Specify whether)
 In this community. 3 mos.
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County Remised
 (c) City or town Carthageville
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME ALBERT JACKSON 250
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 5 - ~~24~~ - day 27
 year 1940 hour 2 P.M. minute _____ M.
 21. I hereby certify that I attended the deceased from 5-20
 _____, 1940, to 5-25, 1940;
 that I last saw h. l. M. alive on 5-25, 1940,
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race Col. 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Barbara Jackson 6. (c) Age of husband or wife if alive 53 years
 7. Birth date of deceased March 8 1885
 (Month) (Day) (Year)

Immediate cause of death Malignant Hypertension ? Duration _____
 Due to _____
 Due to _____ 10 7 1/2
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

8. AGE: Years 55 Months 2 Days 19 If less than one day hr. _____ min. _____
 9. Birthplace Chotard, Miss
 (City, town, or county) (State or foreign country)
 10. Usual occupation Laborer

MOTHER FATHER
 11. Industry or business Common Labor
 12. Name Alec. Jackson
 13. Birthplace Washington Co. Miss
 (City, town, or county) (State or foreign country)
 14. Maiden name Phillis Horton
 15. Birthplace Gazoo City Miss
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Barbara Jackson
 (b) Address Victoria, Miss
 17. (a) Burial (b) Date thereof 5. 29. 40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Carthageville, Mo Smith & Hill
 18. (a) Signature of funeral director Ray, Mrs.
 (b) Address _____
 19. (a) May 28, 1940 (b) Ada Martin
 (Date received local registrar) (Registrar's signature)

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?
595 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature P. J. Quinn (M. D. or other) _____
 Address Carthageville, Mo. Date signed 5-27-40

6-40-17

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.....

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, above space should be left blank.