

S. No 2
M-4-7
I X23159

NOV 12 1949
Registration District No. 1000

Primary Registration District No. 1002

Registrar's No. 3976

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

1. PLACE OF DEATH
 (a) County Jackson
 (b) City or town J. C. Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Bent. Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 hours
 In this community 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Julia Jackson
 3. (b) If veteran, name and war Julia Jackson
 3. (c) Social Security No. No

4. Sex Female 5. Color or race negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Andrew Jackson
 6. (c) Age of husband or wife if alive 60 years
 7. Birth date of deceased Montgomery
 (Month) (Day) (Year)

8. AGE: Year 56 Months - Days -
 If less than one day - hr. - min.

9. Birthplace Texas 3
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife 4

11. Industry or business Fact. Wheeler 9

12. Name Fact. Wheeler 9
 13. Birthplace Texas
 (City, town, or county) (State or foreign country)

14. Maiden name Don't know
 15. Birthplace Don't know
 (City, town, or county) (State or foreign country)

16. (a) Informant Andrew Jackson
 (b) Address 5608 34th St. Texas

17. (a) Burial (b) Date thereof 10-16-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Julius A. ...
 (b) Address 1212 ... St
 19. (a) 10-16-40 (b) M. M. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Jackson
 (c) City or town Kansas City Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5608 34th St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 10 day 13-40
 year _____ hour _____ minute 3:35 A.M.

21. I hereby certify that I attended the deceased from _____ 19____
 that I last saw _____ alive on _____ 19____
 and that death occurred on the date and hour stated above.
 Signature: Deputy Coroner

Immediate cause of death: Cancerous Stomach
 Due to _____
 Due to 46
 Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

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?
 While at work _____ (Specify type of place) _____
 (e) Means of injury _____

23. Signature Deputy Coroner (M. D. or other) _____
 Address _____ Date signed _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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 *Julius A. Fickler*
Licensed Embalmer No. *2229*
P. O. Address *1212 Vine St*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34460

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3976

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town J.C. Mo
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Julia Jackson

3. (b) If veteran name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race negro

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years 56

Months

Days

If less than one day

hr. min.

9. Birthplace _____

(City, town, or county)

(State or foreign country) Texas

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10/16/41

(Date received local registrar)

(b) M. M. Brown

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 13
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

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.

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? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature Russell W. Kerr (M. D. or other)

Address J.C. Mo Date signed _____

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

SUPPLEMENTARY

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, fact should be so stated above.