

Registration District No. 399

Regular Registration District No. 1002

DEC 11 1940

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 45 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1904 Monroe
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME FRANK JACKSON

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife Lillian Jackson 6. (c) Age of husband or wife if alive 1859 years

7. Birth date of deceased Feb 27 (Month) (Day) (Year)

8. AGE: Years 81 Months 8 Days 9 If less than one day hr. min.

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

10. Usual occupation gen Contractor

11. Industry or business _____

12. Name John Jackson

13. Birthplace Iowa (City, town, or county) (State or foreign country)

14. Maiden name Sophie Goodwin

15. Birthplace New Brunswick (City, town, or county) (State or foreign country)

16. (a) Informant Smildred Parfitt

(b) Address 303 Spruce

17. (a) Burial (b) Date thereof 11-9-40 (Month) (Day) (Year)

(c) Place: burial or cremation Smemorial Park

18. (a) Signature of funeral director Quirk & Tobin City _____

(b) Address _____
19. (a) 11-10-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7th year 1940 hour 12:40 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 11-6-40, 19____, to 11-7-40, 19____;

that I last saw him alive on 11-7-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY SCLEROSIS WITH HEMORRHAGE INTO ATHEROMATOUS ABSCESS

Due to _____

Due to _____

Other conditions CEREBRAL SCLEROSIS (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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 Wm. R. Horn (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed 11-7-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

9478

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 Harold Remy

Licensed Embalmer No. 4097

P. O. Address A. C. Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. 4277

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution: H. C. Gen. Hosp.
(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 Frank Jackson

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
..... hr. min.

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

MOTHER FATHER

10. Usual occupation.....

11. Industry or business.....

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)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 11/10/40 (b) M. M. Crowe
(Date received local registrar) (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) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov. day 7 year 40
hour..... minute..... M.

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

Immediate cause of death Coronary Sclerosis
with hemorrhage into
atheromatous plaques.
Due to.....

Due to.....
Other conditions Cerebral Sclerosis
(Include pregnancy within 3 months of death)

Major findings: 9417
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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY