

STANDARD CERTIFICATE OF DEATH

State File No. 40099

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 293

FILED DEC 17 1940

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

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Buyer, Washington Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #3 Nevada Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 yr 8 days
(Specify whether years, months or days) unkersson

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Johnson
(c) City or town Windsor
(If outside city or town limits, write "RURAL")
(d) Street No. unkersson
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

8. (a) PRINT FULL NAME Ollie Lee Jackson

8. (b) If veteran, name war no 8. (c) Social Security No. none

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

6. (b) Name of husband or wife Mr Ollie L. Jackson 6. (c) Age of husband or wife if alive unkersson

7. Birth date of deceased 9 19 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 2 Days 9 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Billie Jackson

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

14. Maiden name Jackson Ware

15. Birthplace Johnson Mo
(City, town, or county) (State or foreign country)

16. (a) Informant State Hosp #3 Records
(b) Address Nevada Mo

17. (a) Lecton Mo (b) Date thereof 11-28-40
(Date of examination, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lecton, Mo.

18. (a) Signature of funeral director A. B. Sumner

(b) Address Lecton Mo.

19. (a) Dec 1, 1940 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 28
year 1940 11 hour 30 minute PM

21. I hereby certify that I attended the deceased from 1-25 1929, to 11-28, 1940
that I last saw him alive on 11-27, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis with General Arteriosclerosis

Due to _____

Due to _____

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) (of Means of injury)

23. Signature A. C. Corey (M. D. or other) MD

Address State Hosp #3 Date signed 11/28/40

RECEIVED

District Health Officer No. 7,

District File Number 12-40-1701

Date Filed 12-4-40

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 MR

W. M. Brauning, Registered Apprentice No. 3377,
working under my personal supervision.

Signed W. M. Brauning

Licensed Embalmer No. 3377

P. O. Address Lecton 9th

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.