No. 2
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X28390

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

FILED APR 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10819

Registration District No. 378 Primary Registration District No. 4232 Registrar's No. 34

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

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Howard
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No.: R.F.D #5 Fayette (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: John Henry Jackman
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Brooksy Jackman
6. (c) Age of husband or wife if alive: 48 years
7. Birth date of deceased: 11 (Month) 6 (Day) 1902 (Year)

8. AGE: Years 38 Months 4 Days 22 If less than one day ____ hr. ____ min.

9. Birthplace: Howard Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business: Farm
MOTHER FATHER
12. Name: John Jackman
13. Birthplace: Howard Co. (City, town, or county) Mo (State or foreign country)
14. Maiden name: Fiona Simmons
15. Birthplace: Howard Co. (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Brooksy Jackman
(b) Address: Howard Co. Mo
17. (a) (Burial) (Cremation) (Removal) (b) Date thereof: 3-30-1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Hillsdale Mo
18. (a) Signature of funeral director: Grant D. Parker
(b) Address: Columbia Missouri
19. (a) 4-1-41 (Date received by local registrar) (b) Anna R. Tindall (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28th year 1941 hour 7 minute 20 A.M.
21. I hereby certify that I attended the deceased from 3-12-1941 19__, to 3-28-1941 19__ 41 that I last saw h. M alive on March 28 19__ 41 and that death occurred on the date and hour stated above.

Immediate cause of death: Uremic Coma — Duration: 4 days
Due to: Acute Nephritis
Due to: Peritonitis due to Perforated duodenal ulcer — 3 wks
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 1/1/ B
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: W. A. Bloom (M. D. or other) M.D.
Address: Fayette Mo Date signed 4-1-41

(Licensed Embalmer's Statement on Reverse Side)

MAY 15 194

RECEIVED
District Health Officer No. 8,
District File Number 4-10-41
Date Filed

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 Stuart P. Parker

Licensed Embalmer No. 2900

P. O. Address Columbia Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.