

No. 2  
4-13-40  
5-17-39  
PI X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41169  
Registrar's No. 4850

JAN 24 1942

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH Jackson  
 (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 No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day  
 (Specify whether years, months or days) 50 yr. 0

3. (a) PRINT FULL NAME Lou Jackson

3. (b) If veteran, name war none 3. (c) Social Security No. 493-12-6904

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Clyde R. Jackson 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Mar. 15 1876  
(Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 12 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

12. Name Thomas W. Simpson

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

14. Maiden name Mrs. Susan Robertson

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

16. (a) Informant Virginia Harrison

(b) Address 5600 Brookside

17. (a) Burial (b) Date thereof Dec 29-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Mrs. C.R. Foster

(b) Address 918 Brookside

19. (a) Dec 29 1941 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson 0483P  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5600 Brookside  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27th  
year 1941 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 12-26-41, 1941, to 12-27-41, 1941;  
that I last saw her alive on 12-27-41, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death: CEREBRAL HEMORRHAGE

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 830  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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) Means of injury \_\_\_\_\_

23. Signature Dr. R. Thom (M. D. or other) 0

Address Dir. of C. Gen. Hospital Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAR 13 1948

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 me

working under my personal supervision. \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

Signed

Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address M. C. Md

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.