

Registration District No. 149

Primary Registration District No. 1002

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 705 East 30th /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XX
In this community 20 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 705 East 30th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME WALKER E. JACKSON

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

4. Sex Ma 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Cecil Jackson 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased April 5 1881
(Month) (Day) (Year)

8. AGE: Years 61 ~~57~~ Months 5 Days 0 If less than one day hr. min.

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

10. Usual occupation City Employee
11. Industry or business City of Kansas City

MOTHER FATHER { 12. Name William Jackson
13. Birthplace Nashville, Tenn
14. Maiden name Mary Jane Lewallen
15. Birthplace Batesville, Ark.
16. (a) Informant Mrs. Cecil Jackson
(b) Address 705 East 30th St.

17. (a) Removal (b) Date thereof 9-6-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Harrison, Ark

18. (a) Signature of funeral director J. M. Wagner
(b) Address Kansas City, Mo.

19. (a) 9/6/42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5th
year 1942 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 1 - 9 2
Sept 5 - 8 2 to Sept 5 - 8 2
that I last saw him alive on Sept 4 8 2
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Duration 3 days
Due to Chronic Interstitial Nephritis
1942

Due to 131A
Other conditions Multiple Neuritis
(Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None
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) () Means of injury _____
23. Signature J. P. Shelton (M. D. or other) _____
Address 929 Walnut Date signed 9-5-42

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

RC mo

Harvard Park Hospital
25th + Locust

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..... *Cecil R. Matthes*.....

Licensed Embalmer No. *3807*.....

P. O. Address *Kansas City, 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, fact should be so stated above.