. S. No. 2
OM—5-42
ev. 5-17-39
I

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 19 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23907

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3038

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K C Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3219 Wayne (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since 1919 (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48 3 8

(c) City or town K C Mo (If outside city or town limits, write "RURAL")

(d) Street No. 3219 Wayne (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME ANDREW L. JACKSON

3. (b) If veteran, name war NO

3. (c) Social Security No. 493-12-7768

4. Sex MALE 5. Color or race 2 NEGRO 6. (a) Single, widowed, married, divorced 1 MARRIED

6. (b) Name of husband or wife Florine

6. (c) Age of husband or wife if alive 48 years

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

8. AGE: Years 61 ~~62~~ Months 9 Days 19 If less than one day hr. min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Garrett Jackson

13. Birthplace Mo (City, town, or county) 0 (State or foreign country)

MOTHER 14. Maiden name Dont know

15. Birthplace Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant Florine Jackson

(b) Address 3219 Wayne

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-43 (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Mo

18. (a) Signature of funeral director Flynn & Greenstreet

(b) Address Kansas City

19. (a) 7-10-43 (Date received local registrar) (b) Dep. T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8 year 1943 hour 6:00 minute A. M.

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

Immediate cause of death

Due to Acute Dilatation of

Due to Heart 95C3

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Insp-History

Duration

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 L. P. Richardson (M. D. or other)

Address 1832 Vine Date signed 7-9-43

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.