

S. No. 2
M-342
7-5-17-39

29653

State File No. _____

Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 374

Primary Registration District No. 6273

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

FILED SEP 2 1943 374

1. PLACE OF DEATH:

(a) County North

(b) City or town Rural, Smith Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Grant City, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County North

(c) City or town Rural
(If outside city or town limits, write "RURAL.")

(d) Street No. Grant City
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BILLY LEROY JACKSON

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 1, 1935
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>8</u>	<u>4</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Lester Jackson

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

14. Maiden name Minnie Oran Jackson

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

16. (a) Informant Minnie Jackson

(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof 7-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Episcopal Church

18. (a) Signature of funeral director Arch C. Temple

(b) Address Grant City Mo.

19. (a) Aug 7 '43 (b) Arthur Scadden
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 18
year 1943 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 7-16 1943 to 7-18 1943
that I last saw him alive on 7-16 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Spontaneous I.D.

Due to _____
Due to _____

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

Major findings: 14

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) (e) Means of injury _____

23. Signature J. H. ...

Address Grant City Mo Date signed 7-20-43

Duration 2 mo

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.....

Irish C. Dunfee

Licensed Embalmer No. *3257*

P. O. Address *Grant 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.