

FILED OCT 20 1943

Registration District No. 99

Primary Registration District No. 4168

1. PLACE OF DEATH

(a) County DE KALB
(b) City or town MAYSVILLE
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County DE KALB
(c) City or town MAYSVILLE
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WM CLAYBORNE 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 M
(b) Name of husband or wife EMMA JACKSON 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased Nov. 26 1867 (Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace DAVIES Co. MISSOURI (City, town, or county) (State or foreign country)

10. Usual occupation MINISTER

11. Industry or business _____

MOTHER FATHER { 12. Name WM JACKSON
13. Birthplace KEN. (City, town, or county) (State or foreign country)
14. Maiden name CELESTINE
15. Birthplace KEN. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Emma Jackson

(b) Address MAYSVILLE MO
17. (a) Removal (b) Date thereof 9-3-43 (Month) (Day) (Year)

(c) Place: burial or cremation ALTA VISTA CEM.

18. (a) Signature of funeral director FUCHER FUNERAL HOME

(b) Address MAYSVILLE MO

19. (a) 9-4-43 (b) [Signature] (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 1 year 1943 hour 12 minute 35 AM
21. I hereby certify that I attended the deceased from Aug. 26 1943 to Sept 1st 1943
that I last saw him alive on Aug 31st 1943 and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis Duration ?

Due to _____
Due to _____

Other conditions acute diarrhea (food poisoning) (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 120 ft

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) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address MAYSVILLE MO Date signed 9/4/43

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

220

1278

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.....

3960

Weymouth, Mass

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.