

FILED APR 15 1944

Primary Registration District No. **1062**

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

1. PLACE OF DEATH: **Jackson**

(a) County **Kansas City**

(b) City or town **Kansas City**

(c) Name of hospital or institution: **1518 Paseo**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **35 years**

In this community **35 years**

2. USUAL RESIDENCE OF DECEASED: **48**

(a) State **Missouri** (b) County **Jackson** **3**

(c) City or town **Kansas City** **0**

(d) Street No. **1518 Paseo**

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

If yes, name country **0**

3. (a) PRINT FULL NAME **William Jackson**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Col**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Sallie Jackson**

6. (c) Age of husband or wife if alive **52 years**

7. Birth date of deceased **January 10 1877**

8. AGE: Years **67** Months **2** Days **25** If less than one day **22** hr. min.

9. Birthplace **Belton County S. C.**

10. Usual occupation **Real Estate Broker**

11. Industry or business

MOTHER FATHER { 12. Name **John Jackson**

13. Birthplace **S. C.**

14. Maiden name **Janie Smith**

15. Birthplace **S. C.**

16. (a) Informant **Sallie Jackson**

(b) Address **1518 Paseo**

17. (a) **burial** (b) Date thereof **4/5/44**

(c) Place: burial or cremation **Highland Cem.**

18. (a) Signature of funeral director **Watkins Bros**

(b) Address **1729 Lydia**

19. (a) **4-5-44** (b) **P. E. Brown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **2nd**

year **1944** hour **11:10** minute **P.** M.

21. I hereby certify that I attended the deceased from **Nov-8-** **1942** to **4-2-** **1944**

that I last saw him alive on **4-2-** **1944**

and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart Failure**

Due to **ANGINA Pectoris**

CORONARY OCCLUSION

Due to **Arteriosclerosis**

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations **NONE**

Of autopsy **NO**

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) **NO**

(b) Date of occurrence **NO**

(c) Where did injury occur? **NO**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **NO**

(e) While at work? **NO** (Specify type of place)

(f) Means of injury **NO**

23. Signature **J. S. Wells** (M. D. or other)

Address **1605 E-18th** Date signed **4-4-44**

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 J. J. Manlove

Licensed Embalmer No. 3994

P. O. Address 2503 Highland

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.