

FILED AUG 10 1944

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

4228

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Glasgow  
(If outside city or town limits, write "RURAL" and name of township)  
(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 4 yrs (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard  
(c) City or town Glasgow  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HUBERT JACKSON

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Mar  
6. (b) Name of husband or wife Mattie Jackson 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased April 22, 1872  
(Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Jacob Jackson  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Christine Kane  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Ms Ollie Cazell

(b) Address Glasgow Mo

17. (a) burial (b) Date thereof 7-10-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Cem

18. (a) Signature of funeral director J. P. McGray

(b) Address Glasgow Mo

19. (a) 7/10/44 (b) J. P. McGray  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8  
year 1944 hour \_\_\_\_\_ minute 20 A.M.

21. I hereby certify that I attended the deceased from MAY  
\_\_\_\_\_ 1942, to July 8, 1944  
that I last saw him alive on July 8, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death M. A. S. STENOSIS

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 J. E. Hunt (M. D. or other) DO.

Address Glasgow Mo Date signed 8-2-44

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

5  
20

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

8-9-41

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 *A.P.M. Gray*

Licensed Embalmer No. *3153*

P. O. Address *Glasgow 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.