

FILED JAN 26 1945

Registration District No. _____

149

Primary Registration District No. 1002

Registrar's No. 194

1. PLACE OF DEATH:

(a) County Jackson, Kansas City,
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3231 Prospect Conv. Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo.
In this community 43.5 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson,
(c) City or town Kansas City,
(If outside city or town limits, write "RURAL")
(d) Street No. Hyde Park Hotel,
36 th. Broadway (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____ X

3. (a) PRINT FULL NAME Charles W. Jackson,

3. (b) If veteran, name war no. 3. (c) Social Security No. none.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Susanne Stout Jackson 6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased 8-2-1858
(Month) (Day) (Year)

8. AGE: Years 86 Months 6 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired,

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant Mrs. Robert Norris,

(b) Address Hyde Park Hotel, Kansas City, Mo.

17. (a) Burial (b) Date thereof 1-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Stine & McClure,
3235 Gillham Plaza, K. C., Mo.

(b) Address _____
19. (a) 1-13-45 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from me
year 1945
that I last saw him alive on Jan 1 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Septic Hypocholesterolemia pneumonia lobar

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 108

Major findings: Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature Clarence J. Capell (M. D. or other) _____
Address 1235 Maitte Bldg Date signed _____

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

MOTHER FATHER

Dr. C. S. Cappell

MAY 22 1953

FEB 1 1948

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 E. M. Plank

Licensed Embalmer No. 1848

P. O. Address H. C. 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.