S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12874

FILED MAY 14 1945

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 505

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #2 St Joseph Mo (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 yrs 12 mos 29 days (Specify whether years, months or days)
In this community yes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette
(c) City or town Lexington (If outside city or town limits, write "RURAL")
(d) Street No. State Hospital #2 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Elizabith Jackson

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

4. Sex Female
5. Color or race Col
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 9 (Month) 9 (Day) 3 (Year)

8. AGE: Years 48 Months ? Days ? If less than one day hr. min.

9. Birthplace Not given (City, town, or county) (State or foreign country)
10. Usual occupation Maid
11. Industry or business
FATHER 12. Name Not given
13. Birthplace " " (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name " "
15. Birthplace " " (City, town, or county) (State or foreign country)
16. (a) Informant County Clerk of
(b) Address Lafayette Co
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/45 (Month) (Day) (Year)
(c) Place: burial or cremation Asylum Cemetery
18. (a) Signature of funeral director Ramsey & Sons
(b) Address 1602 Missouri
19. (a) 6-3-45 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4/28 day year 1945 hour 6 minute a M.

21. I hereby certify that I attended the deceased from Jan 1st 1945 to 4/28 1946 that I last saw her alive on 4/27 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Probably lobar pneumonia of left lung middle lobe	1 wk
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy As given above 5/2 1945

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

23. Signature E. C. Cossins (M. D. or other)
Address State Hospital #2 Date signed 5/2 1945

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(Licensed Embalmer's Statement on Reverse Side)

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 S. F. Ramsey, Registered Apprentice No. ....., working under my personal supervision.

Signed: S. F. Ramsey & Son

Licensed Embalmer No. 4081

P. O. Address 1602 Messaric

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.