

U. S. No. 2  
FORM-2-43  
Rev. 5-17-39  
I X3567

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26466

State File No.

3436

FILED SEP 1 1945  
Registration District No. 179

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital #2 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7-27-45/8-11-45  
40 years. (Specify whether  
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 47  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1509 E. 23 St. 4  
(If rural, give location) 0  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME SOLOMON JACKSON  
(b) If veteran, name war None  
(c) Social Security No. None.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 11  
year 1945 hour 4:30 P.M. minutes 7-27-45 M.  
21. I hereby certify that I attended the deceased from 8-11-45  
to 8-11-45 19 to 19  
that I last saw him alive on 8-11-45  
and that death occurred on the date and hour stated above.

4. Sex M. 2 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widowed  
(b) Name of husband or wife Helia Jackson 6. (c) Age of husband or wife if alive years 10  
7. Birth date of deceased January 10, 1864  
(Month) (Day) (Year)

Immediate cause of death Cerebral Vascular Accident  
Duration

8. AGE: Years 81 Months 7 Days 1 If less than one day hr. min.

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

10. Usual occupation Unemployed.

11. Industry or business

12. Name Stephen Jackson

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

14. Maiden name Martha Jackson  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Record Clerk  
(b) Address General Hospital #2

17. (a) burial (b) Date thereof 8/16/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem. Hopkins 13 Ave.

18. (a) Signature of funeral director [Signature]  
(b) Address 1729 Lydia

19. (a) 8-16-45 (b) Thalidie Holmes  
(Date received local registrar) (Registrar's signature)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 430

Major findings: Of operations

Of autopsy

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. initials) 8-16-45  
Address Gen. Hosp. #2 Date signed

**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. Manbre*

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.**