V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33186

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 1141

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: 221½ Edmond St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ~~None~~ In this community 35 Yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County BUCHANAN
(c) City or town ST. JOSEPH (If outside city or town limits, write "RURAL")
(d) Street No. 221½ EDMOND ST. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME TENIE JACKSON
3. (b) If veteran, name war NO.
3. (c) Social Security No. NO
4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife JOHN ~~None~~
6. (c) Age of husband or wife if alive None years
7. Birth date of deceased March (Month) 10 (Day) 1882 (Year)
8. AGE: 63 Years 4 Months 11 Days; If less than one day ____ hr. ____ min.
9. Birthplace PLATTSBURG MO. (City, town, or county) 0 (State or foreign country)
10. Usual occupation HOUSEKEEPER
11. Industry or business
MOTHER FATHER
12. Name JOHN HICKS
13. Birthplace MO. (City, town, or county) 0 (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 0 (State or foreign country)
16. (a) Informant John Jackson 2Nd Floor
(b) Address 227 E. 55 Place Chicago Ill
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director RAMSEY & SON Mort.
(b) Address 1602 Messanie St.
19. (a) 10/25-1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 21 st year 1945 hour 12 minute midnight M.
21. I hereby certify that I attended deceased from Oct 21st, 1945, to ____, 19____; that I last saw h ~~alive on~~ ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Dysentery	
Due to	
Due to	
Other conditions Arteriosclerosis (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 Coroner
23. Signature B. W. Tadlock (M. D. or other)
Address King Hill Bldg ST. JOSEPH Date signed 10/26/45

1129

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed J. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address 1602 Mesquite

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.