

Registration District No. **128** Primary Registration District No. **2000**

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. John's Hosp. 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Minutes
(Specify whether years, months or days)
 In this community 9 Years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 1300 E. McDaniel
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country: _____

3. (a) PRINT FULL NAME Robert Lee Jackson

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

4. Sex Male **5. Color or race** White **6. (a) Single, widowed, married, divorced** Married

6. (b) Name of husband or wife Elizabeth Jackson **6. (c) Age of husband or wife if alive** UNK. years

7. Birth date of deceased July 31, 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>60</u>	<u>2</u>	<u>26</u>	<u>hr.</u>	<u>min.</u>

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

10. Usual occupation General Mgr.

11. Industry or business Springfield Packing Co.

MOTHER, FATHER

12. Name Henry Jackson

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

14. Maiden name Sadie Smith

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

16. (a) Informant Mrs. Elizabeth Jackson

(b) Address Springfield, Mo.

17. (a) Removal Removal **(b) Date thereof** 10/1/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hutchinson? Kansas

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 10-31-45 **(b) 0 W. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27
 year 1945 hour 2 minute 30p. M.

21. I hereby certify that I attended the deceased from July 1944
 _____, 19____, to present, 19____;
 that I last saw him alive on 10/1/45
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy (Cerebral Hemorrhage)
 Due to Arterio-Sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: 830
 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) (c) Means of injury

23. Signature H.A. Lawrence **(M. D. or other)** _____
 Address Spfld, Mo Date signed 10/29/45

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

NOV 19 1945

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.....

Walter E. Hamilton

Licensed Embalmer No.....

3808

P. O. Address.....

Springfield 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.

+