DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41547

FILED JAN 11 1946

Registration District No. 763 Primary Registration District No. 3031. Registrar's No. 64.

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town De Soto, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jefferson 50
(c) City or town De Soto Rrl 2
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Donald Lee Jackson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 30 (Day) 1943 (Year)
8. AGE: Years 2 Months 8 Days 9 If less than one day hr. min.
9. Birthplace De Soto (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation
11. Industry or business
FATHER 12. Name Robert A. Jackson
FATHER 13. Birthplace Cape Girardeau Mo. (City, town, or county) (State or foreign country) 0
MOTHER 14. Maiden name Ruth Graham
MOTHER 15. Birthplace Jefferson Co. Mo. (City, town, or county) (State or foreign country) 0
16. (a) Informant Robert A. Jackson
(b) Address Festus, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 11 45 (Month) (Day) (Year)
(c) Place: burial or cremation Rose Lawn Memo. Park
18. (a) Signature of funeral director Fink Funeral Parlor
(b) Address Festus, Mo.
19. (a) 12/26/45 (Date received by local registrar) (b) Marie Farris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9 year 1945 hour 7 minute 15 A.M.
21. I hereby certify that I attended the deceased from 8 Dec 1945 to Dec. 9 1945 that I last saw him alive on 9 Dec 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchio pneumonia	1 day.
Due to: Secondary to pertussis	4 wks.
Due to:	
Other conditions (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) no
(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 Karl V. McFinstry (M. D. or other) MD
Address De Soto, Mo. Date signed 10 Dec 45.

-1645

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 1-10-46

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 Eleuan Province

Licensed Embalmer No. 3483

P. O. Address Fortuna Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.