

FILED JUL 11 1947
Registration District No. 128

Primary Registration District No. 2000

State File No. _____

Registrar's No. 562

1. PLACE OF DEATH:

(a) County Green
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 DAYS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Buffalo
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

JAMES HAYDEN JACK

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

4. Sex Male 5. Color or race W 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 MAY 13 1933
(Month) (Day) (Year)

8. AGE: Years 14 Months 1 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Buffalo Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name JAMES JACK

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

14. Maiden name JEAN LIPK

15. Birthplace Buffalo Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant James Jack

(b) Address Buffalo Mo.

17. (a) Burial (b) Date thereof 6-25-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (c) Signature of funeral director L. B. Jones

(b) Address Buffalo Mo.

19. (a) 6-25-47 (b) W. S. Hendley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23 year 1947 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from May 5 1947 to June 23 1947 that I last saw him alive on June 23 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Constructive fever Duration 2 years

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (Specify means of injury) OV

23. Signature [Signature] (M. D. or other) _____

Address Springfield Mo. Date signed 6/24/47

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

MOTHER, FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

90B

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..... *Marie B. Jones*

Licensed Embalmer No. *4322*

P. O. Address *Buffalo, 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.