

FILED OCT 27 1947
Registration District No. 155

Primary Registration District No. 5579

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

1. PLACE OF DEATH:

(a) County... Jasper

(b) City or town... Webb City (MINERAL TWP. RURAL)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution...
2 miles North of Webb City /
(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... 20 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... Missouri (b) County... Jasper 49

(c) City or town... Rural MONERAL TWP.
(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 Arvilla D. Jackson

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month... October day... 13
year... 1947 hour... 2 minute... A. M.

4. Sex... Female 5. Color or race... W. 6. (a) Single, widowed, married, divorced... Married

6. (b) Name of husband or wife... A. E. Jackson 6. (c) Age of husband or wife if alive... years

7. Birth date of deceased... February 10 1891
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-28-47 to 10-13-47 that I last saw her alive on 10-11-47 and that death occurred on the date and hour stated above.

Immediate cause of death: HEART BLOCK MYOCARDITIS

8. AGE: Years Months Days If less than one day

56 8 3 hr. min

Other conditions: HYPERTENSION ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: NEPHRITIS

Of operations: ...

Of autopsy: ...

9. Birthplace... Jay Oklahoma
(City, town, or county) (State or foreign country)

10. Usual occupation... at home

11. Industry or business.....

12. Name... No data

13. Birthplace... No data
(City, town, or county) (State or foreign country)

14. Maiden name... No data

15. Birthplace... No data
(City, town, or county) (State or foreign country)

16. (a) Informant... Hus. A. E. Jackson
(b) Address... Webb City, Mo.

17. (a) burial (b) Date thereof... 10/15/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation... Ozark Memorial

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)

Signature... P. M. Carter (M.D. or other) 90.
Address... CARTERVILLE Date signed... 10-15-47

18. (a) Signature of funeral director... Hedge-Lewis
(b) Address... Webb City, Mo.

19. (a) OCT. 15, 1947 (b) P. M. Carter
(Date received: local registrar) (Registrar's signature)

MO

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 _____

Leonard J. Lewis 2.

Registered Apprentice No. *46*

working under my personal supervision.

Signed _____

E. M. Hedge

Licensed Embalmer No. *2859*

P. O. Address. *St. Louis, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *N 02*Registration District No. *155*Primary Registration District No. *5579*Registrar's No. *153*

1. PLACE OF DEATH:

(a) County *Jasper rural*
(b) City or town _____
(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 _____)In this community _____
years, months or days)3. (a) PRINT
FULL NAME *Arvilla D. Jackson*3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex *F* 5. Color or race *W*
6. (a) Single, widowed, married,
divorced *W*6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if
alive _____7. Birth date of deceased *Feb 10 1900*
(Month) (Day) (Year)8. AGE: Years *56* Months _____ Days _____
(Less than one day _____ hr. _____ min.)9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb* 23
year *1947* hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____
to _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy *BIB*

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 _____23. Signature *[Signature]* (M. D. or other) *Feb 23 1947*Address *[Address]* Date signed *Feb 23 1947*

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

MOTHER FATHER

SUPPLEMENTARY

S-34839