

FILED MAR 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8878

BIRTH NO. 49-016079 REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 58

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u> <u>U</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u> <u>WEBB</u> CITY <u>()</u>		c. LENGTH OF STAY (In this place) <u>4 1/2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jane Chinn Hospital</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u> <u>3</u>	
		d. STREET ADDRESS (If rural, give location) <u>Joplin Rt. # 1</u> <u>1</u>	

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>Infant Son of Mr. & Mrs. Walter Jackson</u>				<u>March 18 1949</u>

5. SEX <u>Male</u> <u>U</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>March 18, 1949</u>	9. AGE (In years last birthday)	# UNDER 1 YEAR	# UNDER 24 HRS.
				<u>4</u>	<u>50</u>	<u>50</u>
10a. USUAL OCCUPATION (Give kind of work done during past working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Webb City, Missouri</u> <u>U</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Walter Jackson</u>	13b. MOTHER'S MAIDEN NAME <u>Minnie Rayborn</u>	14. NAME OF HUSBAND OR WIFE
		<u>-----</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Walter Jackson</u>	ADDRESS <u>Joplin Rt. # 1</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Head injury at birth</u> DUE TO (c) <u>None</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>None</u>	

19a. DATE OF OPERATION <u>✓</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-18-49 5:25A 189, to 3-18-49 5:25A 189, and that death occurred at 5:25A m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)	23b. ADDRESS <u>Box 2 Webb City, Mo</u>	23c. DATE SIGNED <u>3/19/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 19, 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Carterville Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Carterville, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>MCH 19: 1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Johnston-Arnce-Simpson, Webb City, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Harvey P. Crane

Licensed Embalmer No. 4463

Signed _____
Student Embalmer

P. O. Address St. Paul City, 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.