

FILED AUG 24 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26698  
Registrar's No. 720

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD</b>	
c. LENGTH OF STAY (In this place) <b>2 Wks.</b>		39	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>GREENE COUNTY HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>2347 N. TRAVIS</b>	

3. NAME OF DECEASED (Type or Print) <b>JESS</b>	a. (First)	b. (Middle) <b>B.</b>	c. (Last) <b>JACKSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>AUGUST 13 1949</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>25 AUGUST 1885</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>ENOCH JACKSON</b>	13b. MOTHER'S MAIDEN NAME <b>JANE SHEFFIELD</b>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give post or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT'S SIGNATURE OR NAME <b>GRACE MCGUIRK</b>	ADDRESS <b>SPEED. MO.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Tuberculosis, Pulmonary</b>		DUE TO (b) _____		<b>Not known</b>
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____		<b>Not known</b>
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <b>Myocarditis, Chronic</b>		<b>Not known</b>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <b>No operation</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **8-7**, 1949, to **8-13**, 1949, that I last saw the deceased alive on **8-13**, 1949, and that death occurred at **2:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>James R. Ames M.D.</b>	(Degree or title)	23b. ADDRESS <b>Springfield Mo.</b>	23c. DATE SIGNED <b>8-15-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>8-14-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN</b>	24d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD MO.</b>
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DATE REC'D BY LOCAL REG. <b>8-15-49</b>	REGISTRAR'S SIGNATURE <b>W. E. Handley</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. Klingner &amp; Co.</b>	ADDRESS <b>Springfield Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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copy

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**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.

Student .....  
Student Embalmer

Signed *Ogle Stone Jr.*

Licensed Embalmer No. 417E

P. O. Address Springfield

**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.