

FILED NOV 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33720BIRTH NO. _____ REG. DIST. NO. 142 PRIMARY REG. DIST. NO. 4231 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mtn. View, Missouri</u>		c. LENGTH OF STAY (in this place) OR TOWN <u>15 hrs.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Shaffers hospital</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Willow Springs,</u>	
		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CARY</u>	b. (Middle) <u>HOFFMAN</u>	c. (Last) <u>JACKSON</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>Oct. 22, 1949</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 25, 1885</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
--------------------	-------------------------------	---	--	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Crawford county Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	-----------------------------------	---	---

13a. FATHER'S NAME <u>Joseph Jackson</u>	13b. MOTHER'S MAIDEN NAME <u>Jane A. Maycroft</u>	14. NAME OF HUSBAND OR WIFE <u>Julia Ann Jackson</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>489-16-1507</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Julia Ann Jackson</u>	ADDRESS <u>Willow Springs</u>
--	--	--	-------------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>unknown</u>
	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>Arterial Hypertension</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>331X</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

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)	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 Oct 5, 1949, to Oct 22, 1949, that I last saw the deceased alive on Oct-22, 1949, and that death occurred at 2 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Thomas T. Francisco</u> (Degree or title) <u>DO</u>	23b. ADDRESS <u>Willow Springs, Mo.</u>	23c. DATE SIGNED <u>10/24/49</u>
---	---	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/24/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Nease Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Willow Springs, Mo.</u>
---	---------------------------	--	--

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>126</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Burns Funeral Home</u>	ADDRESS <u>Willow Springs,</u>
--------------------------	----------------------------------	--	--------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

RECEIVED

11/3/49

District Health Officer No. **41**

District File Number 1199-686

Date Filed 11/4/49

JAN 21 1950

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.

Fred W. Barnes

Signed Fred W. Barnes

Signed.....
Student Embalmer

Licensed Embalmer No. 4614

P. O. Address Willow Springs, Miss

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.