

FILED FEB 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4681

State File No. _____

245

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fayette</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fayette</u>	
c. LENGTH OF STAY (in this place) <u>10 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>New Addition</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>New Addition</u>		d. STREET ADDRESS <u>New Addition</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>-</u> c. (Last) <u>Jackman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 3 1950</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 15, 1879</u>
9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>28</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>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Howard Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Pete Jackman</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Arnold</u>	
14. NAME OF HUSBAND OR WIFE <u>Lena Cooper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Lena Jackman</u>		ADDRESS <u>Fayette, MO</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute pyelonephritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> ANTECEDENT CAUSES <u>uremia</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>6</u>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <u>January 29 1950</u> , to <u>Feb 3</u> , 1950, that I last saw the deceased alive on <u>Feb 1</u> , 1950, and that death occurred at <u>2 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Francis J. Shanley M.D.</u> (Degree or title)		23b. ADDRESS <u>Fayette, Mo.</u>	23c. DATE SIGNED <u>2-6-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2/5/50</u>	24c. NAME OF CEMETERY OR CREMATORY, <u>Hilldale Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Hilldale, Mo.</u>
DATE REC'D BY LOCAL REG. <u>2-6-50</u>	REGISTRAR'S SIGNATURE <u>Mary H. Shell</u> <u>436</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph A. Carr</u> ADDRESS <u>Fayette, Mo</u>	

RECEIVED FEB 8

District Health Officer No. 8.

District File Number.....

Date Filed 2-21-50

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 *Ralph A. Cass*.....

Licensed Embalmer No. 3340

P. O. Address Gayette 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.