

FILED JUL 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20815
State File No.

BIRTH NO. _____ REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 4273 Registrar's No. 67

550

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

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) Marionville		c. CITY (If outside corporate limits, write RURAL and give township) Marionville	
c. LENGTH OF STAY (in this place) 17 yrs		d. STREET ADDRESS (If rural, give location) 0550	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Parthena b. (Middle) Jackson c. (Last) Jackson			4. DATE OF DEATH June 19, 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 15, 1882	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months 2 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Christian County Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Hunt		13b. MOTHER'S MAIDEN NAME Judy Maynard		14. NAME OF HUSBAND OR WIFE Frank Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr Frank Jackson Marionville Mo.	

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) Cerebral hemorrhage		ANTECEDENT CAUSES		5 days	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		year	
DUE TO (b) Arterio sclerosis		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death.				331X	

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 1946 to June 19, 1950, that I last saw the deceased alive on June 19, 1950, and that death occurred at 1 P.M., from the causes and on the date stated above.

23a. SIGNATURE A. P. Coyette (Degree or title) O.M.E.		23b. ADDRESS Aurora Mo.		23c. DATE SIGNED 6/20/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/21/50		24c. NAME OF CEMETERY OR CREMATORY Deleware Cemetery		24d. LOCATION (City, town, or county) (State) Christian County Mo.	
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DATE REC'D BY LOCAL REG. June 21-50		REGISTRAR'S SIGNATURE Oran McNeil		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. D. Surrige - Marionville Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

650-725-

DISTRICT HEALTH OFFICE #6
MONETT, MISSOURI

REC JUN 28 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.

Student
Student Embalmer

Signed

Herman Ferridge

Licensed Embalmer No.

3072

P. O. Address

Marionville

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.