

FILED SEP 13 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29176

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 34A PRIMARY REG. DIST. NO. 4514 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Green City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Green City</u>	
c. LENGTH OF STAY (in this place) <u>17 years</u>		d. STREET ADDRESS (If rural, give location) <u>No street address</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Home in Green City</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Rosa</u> b. (Middle) <u>Lee</u> c. (Last) <u>Jackson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 30, 1950</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 7, 1878</u>
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>	IF UNDER 48 HRS. Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>James Shepherd</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Arthur</u>	14. NAME OF HUSBAND OR WIFE <u>Nova Jackson-Deceased</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 ADDRESS <u>Mrs. Pauline Robinson, Green City,</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Circulatory Failure</u> <u>Decompensated Hypertensive Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Advanced Age</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>443x</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>3 years</u> <u>20 years</u>			
19a. DATE OF OPERATION -----		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	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) <u>Green City Sullivan Missouri</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. -----	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>Aug. 25, 1950</u> , to <u>Aug. 30, 1950</u> , that I last saw the deceased alive on <u>Aug. 30, 1950</u> , and that death occurred at <u>5 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Robert N. Clarke, D.O.</u> (Degree or title)		23b. ADDRESS <u>Green City, Missouri</u>	23c. DATE SIGNED <u>Aug. 31-1950</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept. 1, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Green City, Mo.</u>
DATE REC'D BY LOCAL REG. <u>Sept. 5, 1950</u>	REGISTRAR'S SIGNATURE <u>Laura Catlett</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn E. Kent &amp; Son</u>	ADDRESS <u>Green City, Mo.</u>

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

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Date Received: SEP 1 1950

DISTRICT HEALTH OFFICE #2

District File Number 9-50-1

Date Filed: SEP 12 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 *Karl R. Kent* .....

Licensed Embalmer No. *4689* .....

P. O. Address *Spring 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.