

FILED OCT 10 1950

STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2933

1. PLACE OF DEATH
 a. COUNTY St. Louis
 b. CITY (If outside corporate limits, write RURAL and give township) Weldon
 c. LENGTH OF STAY (in this place) 3 weeks
 d. FULL NAME OF HOSPITAL OR INSTITUTION 6470 Myron Place

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 a. STATE Arkansas b. COUNTY Madison
 c. CITY (If outside corporate limits, write RURAL and give township) Walnut Ridge Ark
 d. STREET ADDRESS (If rural, give location) _____

3. NAME OF DECEASED
 a. (First) Lidia b. (Middle) Cordelia c. (Last) Jackson

4. DATE OF DEATH (Month) (Day) (Year)
Sept 28, 1950

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH July 27, 1881

9. AGE (In years last birthday) Months Days Hours Mins.
69 7 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country)
Madison Township Ark.

12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Thomas W. Spurlack

13b. MOTHER'S MAIDEN NAME Martha Murphy

13c. NAME OF HUSBAND OR WIFE Charles William Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
O. H. Tinker 6470 Myron Place

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
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY EMBOLISM
 ANTECEDENT CAUSES
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (b) AURICULAR FIBRILLATION
 DUE TO (c) ARTERIOSCLEROTIC CARDIAC DISEASE
 II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.
GENERAL ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH
5 MIN.
ONE MONTH
3 YEARS
5 YEARS

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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)
4500

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from AUG. 28, 1950, to SEPT. 29, 1950, that I last saw the deceased alive on SEPT. 29, 1950, and that death occurred at 8:15 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
Robert A. Hall, M.D. U

23b. ADDRESS
3902 LAFAYETTE ST. LOUIS, Mo.

23c. DATE SIGNED
SEPT. 29, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 1st, 1950

24c. NAME OF CEMETERY OR CREMATORY Lane Cemetery

24d. LOCATION (City, town, or county) (State)
Walnut Ridge Ark.

DATE REC'D BY LOCAL REG. 9-29-50

REGISTRAR'S SIGNATURE
H. Polonke M.D./M. Bill-Campbell

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Funeral Home 4215 S. Lindell

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

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

Ruf E. Campbell

Licensed Embalmer No. *3881*

P. O. Address.....

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.