

FILED MAR 12 1951

## STANDARD CERTIFICATE OF DEATH

Dr. Vail

State File No. 4465

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BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 193

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hosp.		d. STREET ADDRESS (If rural, give location) 225 S. Scenic Drive			
3. NAME OF DECEASED (Type or Print) Effie		a. (First)		b. (Middle) Jackson	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) March 5, 1951			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Feb. 23 1889		9. AGE (In years last birthday) 62		10. F UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) Springfield, Mo.		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Thomas S. Gross		13b. MOTHER'S MAIDEN NAME Martha Wylie		14. NAME OF HUSBAND OR WIFE O.C. 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. NO		17. INFORMANT'S SIGNATURE, OR NAME AND ADDRESS O.C. Jackson Springfield, Mo.	
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) Mesenteric Thrombosis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Cecum  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH     153x	
19a. DATE OF OPERATION 2/24/51		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Cecum		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 2-14, 1951, to 3-5, 1951, that I last saw the deceased alive on 3-5, 1951, and that death occurred at 1:05 p.m., from the causes and on the date stated above.					
23a. SIGNATURE O.A. Vail M.D.		(Degree or title)		23b. ADDRESS Springfield Mo.	
23c. DATE SIGNED 3-6-51					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/7/51		24c. NAME OF CEMETERY OR CREMATORY Hazelwood	
24d. LOCATION (City, town, or county) (State) Springfield, Mo.					
DATE REC'D BY LOCAL REG. 3-7-51		REGISTRAR'S SIGNATURE W.G. Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS H.H. Lohmeyer Springfield, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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.

Student Embalmer No. ....

Signed \_\_\_\_\_

Signed.....  
Student Embalmer

Licensed Embalmer No. 4815

P. O. Address Springfield, 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.