

FILED OCT 21 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35591

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 181 PRIMARY REG. DIST. NO. 5677- Registrar's No. 39

570

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Briese</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Briese</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>0572</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARK</u>	b. (Middle) <u>ELLEN</u>	c. (Last) <u>JACKSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 16 1952</u>
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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>Nov 26 1876</u>	9. AGE (In years last birthday) <u>75</u> Months <u>10</u> Days <u>20</u>	IF UNDER 1 YEAR OF AGE: Hours <u>0</u> Mins. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Briese Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.B.</u>
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13a. FATHER'S NAME <u>John W Lynn</u>	13b. MOTHER'S MAIDEN NAME <u>Louisa Holloway</u>	14. NAME OF HUSBAND OR WIFE <u>James F Jackson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John F Lynn</u> ADDRESS <u>Briese Mo</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</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) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct. 10, 1952, to Oct 16, 1952, that I last saw the deceased alive on Oct 15, 1952, and that death occurred at 1230 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R. M. Penn, M.D.</u>	23b. ADDRESS <u>Dixie Mo.</u>	23c. DATE SIGNED <u>Oct 17 52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 17 52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Briese Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Briese Mo.</u>
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DATE REC'D BY LOCAL REG. <u>10-20-52</u>	REGISTRAR'S SIGNATURE <u>Mrs. Clarence Kientz</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne M &amp; Coy Troy Mo</u> ADDRESS _____
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(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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Wayne McEoy*

Licensed Embalmer No. *3586*

P. O. Address *Troy 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.