

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1488**
REGISTRAR'S NO. **94**

FILED FEB 9 1953

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		REGISTRAR'S NO. 94	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Wyandotte			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo		c. LENGTH OF STAY (In this place) 25 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		8150	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wheatly Providence Hospital				d. STREET ADDRESS (If rural, give location) 835 Nebraska St			
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) L.		c. (Last) Jackson		4. DATE OF DEATH (Month) (Day) (Year) January 5, 1953	
5. SEX 2 Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 3-12-1882	
9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Common Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ruston, La	
11. BIRTHPLACE (State or foreign country) Ruston, La		12. CITIZEN OF WHAT COUNTRY? U. S. A		13a. FATHER'S NAME J. N. Jackson		13b. MOTHER'S MAIDEN NAME Addie Lewis	
13a. FATHER'S NAME J. N. Jackson		13b. MOTHER'S MAIDEN NAME Addie Lewis		14. NAME OF HUSBAND OR WIFE Dorothy Jean 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 Dorothy Jean Jackson ADDRESS 835 Nebraska City, Kansas			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Spinal tuberculosis, intestinal cancer, metastatic carcinoma stomach				INTERVAL BETWEEN ONSET AND DEATH 151 X	
19a. DATE OF OPERATION 12-10-52		19b. MAJOR FINDINGS OF OPERATION Insoperable Carcinoma Stomach				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide		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 1-22, 1952 to 1-5, 1953 that I last saw the deceased alive on 1-5, 1953 and that death occurred at 6:50 A. M. , from the causes and on the date stated above.							
23a. SIGNATURE C. W. Alexander				23b. ADDRESS 1521 S. 1st St		23c. DATE SIGNED 1-6-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8 January 1953		24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City Kansas	
DATE REC'D BY LOCAL REG. 1-9-53		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. J. W. Jones ADDRESS 440 State Ave			

(Licensed Embalmers' Statement on Reverse Side)

Kansas City, Kansas.

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.....
Student Embalmer

Signed *Ernest English*

Licensed Embalmer No. *4105*

P. O. Address *440 State Ave N.C.*

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.