

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35070**

FILED OCT 19 1953

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1096**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph 0117 0	
c. LENGTH OF STAY (in this place) 19 years		d. STREET ADDRESS (If rural, give location) 1521 S. 17th St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 922 S. 15th St.			

3. NAME OF DECEASED (Type or Print) a. (First) Stella b. (Middle) May c. (Last) Jackson			4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1953		
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5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH April 12, 1886		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 67	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Buchanan County, Mo. 0		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Sylvester Wright		13b. MOTHER'S MAIDEN NAME Tempa Simms		14. NAME OF HUSBAND OR WIFE James A.	
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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. unk.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. James Jackson, 1521 S. 17th, St. Joseph, Mo.	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Right Hemiplegia DUE TO (c) 331X			INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Woman suffered a stroke at an apoplexy two years ago and has been an invalid since			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION ago and has been an invalid since		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 ^{viewed} ~~observed~~ the deceased from **on 10/9, 1953**, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **2:50 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. F. Mundy M.D. (Coroner)		23b. ADDRESS St. Joseph, Mo.		23c. DATE SIGNED 10/9/53	
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24. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 10/10/1953		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
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DATE REC'D BY LOCAL REG. Oct. 15, 1953		REGISTRAR'S SIGNATURE Esther M. Allison		48-2 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Newton Bowman Funeral Home	
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(Licensed Embalmer's Statement on Reverse Side) **219 West 7th**

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 *William Spalding* _____

Licensed Embalmer No. *4535* _____

P. O. Address *319 S. 1st St. Joseph, 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.