

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 11 1954

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5463 Registrar's No. 6

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 Rural 1st Jackson

c. CITY OR TOWN Rural 1st Jackson d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Strafford RFD#3

e. STREET ADDRESS (If rural, give location) Strafford RFD#3 0290

3. NAME OF DECEASED (Type or Print)
a. (First) BESSIE b. (Middle) R. c. (Last) JACKSON

4. DATE OF DEATH (Month) (Day) (Year) January 1 1954

5. SEX Female

6. COLOR OR RACE White

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

8. DATE OF BIRTH 16 Feb. 1876

9. AGE (In years last birthday) 78 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____

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

10b. KIND OF BUSINESS OR INDUSTRY In Home

11. BIRTHPLACE (City and State or Foreign Country) Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME W.W. Womack

13b. MOTHER'S MAIDEN NAME Henrietta Ezell

14. NAME OF HUSBAND OR WIFE Deceased

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 ADDRESS Roy Jackson Strafford, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) **MEDICAL CERTIFICATION**

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complications which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypo-static pneumonia

INTERVAL BETWEEN ONSET AND DEATH 10 Days

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. Fracture right hip

6 weeks

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) 029 (STATE)

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 11-28-, 1953, to 12-7-, 1953, that I last saw the deceased alive on 12-7-, 1953, and that death occurred at 6:45 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul C. Merton M.D.

23b. ADDRESS 1630 N. Jefferson, Springfield

23c. DATE SIGNED 1-2-54

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

24b. DATE 1-3-54

24c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery

24d. LOCATION (City, town, or county) (State) Greene County, Missouri

DATE REC'D BY LOCAL REG. 1-5-54

REGISTRAR'S SIGNATURE Edith Williamson

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. KLINGNER & CO. Springfield, Mo.

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.....
Signature of Student Embalmer

Signed..... *Ogle Stone Jr.*

Licensed Embalmer No. *412*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.