

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2055

State File No.

BIRTH **FILED FEB 5 1954** REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **233**

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE: (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Ralls	
b. CITY (If outside corporate limits, write RURAL and give township) Hannibal		c. CITY OR TOWN New London	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth		e. STREET ADDRESS (If rural, give location) 0870	
3. NAME OF DECEASED a. (First) Edward b. (Middle) Mourve c. (Last) Jackson		4. DATE OF DEATH (Month) (Day) (Year) 1 - 14 - 54	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Oct. 29 - 1908
9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	11. BIRTHPLACE (City and State or Foreign Country) New London, MO
13a. FATHER'S NAME John Jackson		13b. MOTHER'S MAIDEN NAME Hattie Porter	14. NAME OF HUSBAND OR WIFE Mary Bee Jackson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME 331X ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	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) _____ 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		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) 331X	
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 **Dec 10, 1953** to **Jan 14, 1954**, that I last saw the deceased alive on **14 Jan, 1954**, and that death occurred at **7:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Deedee or title) W. J. Beer		23b. ADDRESS Hannibal MO		23c. DATE SIGNED 1-27-54	
24a. BURIAL - CREMATION - REMOVAL (Specify)		24b. DATE Jan 17 - 54		24c. NAME OF CEMETERY OR CREMATORY Fairview	
24d. LOCATION (City, town, or county) (State) New London MO					

DATE REC'D BY LOCAL REG. 1-28-54		REGISTRAR'S SIGNATURE Dr. M. J. ...		25. FUNERAL DIRECTOR'S SIGNATURE Geo E. Roberts	
				ADDRESS Hannibal	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED FEB 3 1954
MARION CO. HEALTH DEPT.
DATE FILED FEB 3 1954

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 Geo E Roberts

Licensed Embalmer No. 211

P. O. Address Hamm

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.