

FILED JUN 1 1954

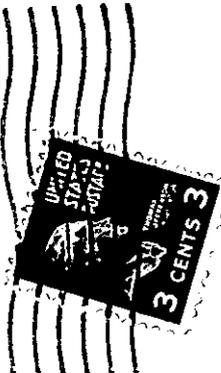
THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16784

BIRTH NO. _____		REG. DIST. NO. <u>2611</u>		PRIMARY REG. DIST. NO. <u>5998</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>OZARK</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>OZARK</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>DORA</u>		c. LENGTH OF STAY (in this place) <u>65 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>DORA</u>		<u>0 270</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>X</u>				d. STREET ADDRESS (If rural, give location) <u>X</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>HARVEY</u> b. (Middle) <u>THOMAS</u> c. (Last) <u>JACKSON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4-4-54</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>		8. DATE OF BIRTH <u>3-10-1880</u>		
9. AGE (in years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months <u>24</u> Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>James Jackson</u>			13b. MOTHER'S MAIDEN NAME <u>UNK</u>			14. NAME OF HUSBAND OR WIFE <u>X</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>X</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME <u>CLAUDE JACKSON</u> ADDRESS <u>KANSAS CITY, MO</u>				
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) <u>Cancer Maxillary Antrum 4 yrs</u>					INTERVAL BETWEEN ONSET AND DEATH _____	
		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. <u>160X</u>						
19a. DATE OF OPERATION <u>6-19-51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Massive Cancer Antrum</u>				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) _____				
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 <u>11-7, 1922, to 1/4/53</u> , 19____, that I last saw the deceased alive on <u>1-9</u> , 19____, and that death occurred at <u>9:00 pm</u> from the causes and on the date stated above.								
23a. SIGNATURE <u>Gr B Stoll MB</u> (Degree or title) _____				23b. ADDRESS <u>West Plains</u>		23c. DATE SIGNED <u>4/20/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>4-8-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hale</u>		24d. LOCATION (City, town, or county) (State) <u>Dora, Mo</u>		
DATE REC'D BY LOCAL REG. _____		REGISTRAR'S SIGNATURE <u>Edgar A. Snider</u>		25. FUNERAL DIRECTOR'S SIGNATURE _____		ADDRESS <u>Robertsons, West Plains, Mo</u>		



ROBERTSONS,
WEST PLAINS MO



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 _____

Licensed Embalmer No. 3430

P. O. Address West Plains

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.