

FILED OCT 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30644**
Registrar's No. **4346**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. 4346		
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Livingston				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 4 wks.		c. CITY OR TOWN Chillicothe		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital				STREET ADDRESS (If rural, give location) Rural Route No. 5 0590				
3. NAME OF DECEASED (Type or Print) a. (First) GROVER b. (Middle) C. c. (Last) JACKSON			4. DATE OF DEATH (Month) (Day) (Year) September 11, 1954					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH January 28, 1892		9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (City and State or Foreign Country) Greer County, Oklahoma		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13a. FATHER'S NAME Lafayette Jackson			13b. MOTHER'S MAIDEN NAME Margaret Green		14. NAME OF HUSBAND OR WIFE? Lavernia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS VA Hospital Official Records					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infarction of myocardium due to arteriosclerosis. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			INTERVAL BETWEEN ONSET AND DEATH 2 months 8 years 4200	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Minute) VA		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 August 15, 1954 , to September 11, 1954 , and that death occurred at 4:50a m., from the causes and on the date stated above.								
23a. SIGNATURE Dorthea Weybright (Degree or title)				23b. ADDRESS VA Hospital, Kansas City, Mo.		23c. DATE SIGNED 9-11-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-11-54	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Chillicothe, Missouri			
DATE REC'D BY LOCAL REG. 9-11-54		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCURE UND. CO.		ADDRESS K.C.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 emb

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Eugene Kenna*.....

Licensed Embalmer No. *463*.....

P. O. Address *Lamer E*.....

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