

FILED OCT 28 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32892

State File No. ....

BIRTH NO. <u>67-42-54</u>		REG. DIST. NO. <u>1</u>	PRIMARY REG. DIST. NO. <u>3000</u>	Registrar's No. <u>382</u>
1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kirksville</b>		c. LENGTH OF STAY (in this place) <b>14 hours</b>	c. CITY OR TOWN <b>Kirksville</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Kirksville Osteopathic Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>1109 S. Baird</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Brenda</b>		b. (Middle) <b>Dean</b>	c. (Last) <b>Jackson</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>October 14-1954</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-14-54</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min. <b>14 30</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Kirksville, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Buel Dean Jackson</b>		13b. MOTHER'S MAIDEN NAME <b>Wilma Darlene Gregory</b>		14. NAME OF HUSBAND OR WIFE
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 <i>Wilma Darlene Jackson</i> ADDRESS <b>1109 S. Baird Kirksville Mo</b>	
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) <b>Medullary failure</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>inadequate development</b> DUE TO (c) <b>immaturity</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>premature labor</b>		INTERVAL BETWEEN ONSET AND 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)		
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>10-14</u> , 19 <u>54</u> , to <u>10-14</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>10-14</u> , 19 <u>54</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <i>W.C. Reinhold</i>		23b. ADDRESS <b>D. O. H. Kirksville</b>		23c. DATE SIGNED <b>10-15-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Retained</b>	24b. DATE <b>10-15-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Laboratory KCOS</b>	24d. LOCATION (City, town, or county) (State) <b>Kirksville Mo.</b>	
DATE REC'D BY LOCAL REG. <b>10-22-54</b>	REGISTRAR'S SIGNATURE <i>Kate Lambert</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>George Lytle</i> <b>KOH, Kirksville</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**