

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40715**  
Registrar's No. **13**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023**

1. PLACE OF DEATH a. COUNTY <b>Henry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Henry</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Clinton</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Clinton</b>	
c. LENGTH OF STAY (in this place) <b>29 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>306 W Rogers</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS	

3. NAME OF DECEASED (Type or Print) <b>SAMUEL WALTER JACKSON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>12-29-1954</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	
8. DATE OF BIRTH <b>OCT 5, 1890</b>		9. AGE (in years last birthday) <b>56</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Richeson Co. Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Henry J Jackson</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Wilson</b>		14. NAME OF HUSBAND OR WIFE <b>Dollie M Jackson</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>490-05-8725</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Dollie M Jackson</b> ADDRESS <b>Clinton Mo</b>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Squamous Cell Carcinoma of right lobe lung</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
		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. <b>None</b>					

19a. DATE OF OPERATION <b>1/11/55</b>		19b. MAJOR FINDINGS OF OPERATION <b>Squamous cell carcinoma lip reclin operation done</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No</b>		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) <b>None</b>		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 28, 1954**, to **Dec 29, 1954**, that I last saw the deceased alive on **Dec 29, 1954** and that death occurred at **10:20** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>S.R. Migher M.D.</b>		23b. ADDRESS <b>Clinton Mo</b>		23c. DATE SIGNED <b>12/30/54</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1-1-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Englewood Cem. Clinton</b>		24d. LOCATION (City, town, or county) (State) <b>Mo</b>	
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DATE REC'D BY LOCAL REG. <b>Jan-1-55</b>		REGISTRAR'S SIGNATURE <b>Florence Adair</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Nickman &amp; Dunning</b> ADDRESS <b>Clinton Mo</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 21 1938

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

*Robert L Dunning*

Licensed Embalmer No. *4718*

P. O. Address *Clinton Mo.*

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