

FILED FEB 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH783
STATE FILE NUMBERRegistration District No. 98 Primary Registration District No. 5365 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Lincoln Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lincoln Township</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8 Mi. N.W. Jamesport.</u>		Length of stay in 1b	d. STREET ADDRESS <u>8 Mi. N.W. Jamesport.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Karr Jackson</u>			4. DATE OF DEATH Month Day Year <u>January 13 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1910</u>	9. AGE (In years last birthday) <u>46</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Henry B. Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Susannah Edwards</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-30-1871</u>	17. INFORMANT Address <u>Mrs. Arthur K. Jackson Jamesport</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b)
					DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>Death on Arrival</u> and last saw her alive on _____ Death occurred at <u>11 A. m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Edward L. Dickerson M.D.</u>			22b. ADDRESS <u>Gallatin Mo.</u>		22c. DATE SIGNED <u>1/29/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>1-16-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Gallatin, Missouri</u>		
24. FUNERAL DIRECTOR <u>L. C. Dickerson</u> ADDRESS <u>Hope Funeral Home, Gallatin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-24-57</u>	26. REGISTRAR'S SIGNATURE <u>Virginia M. Engelhart</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

21-0

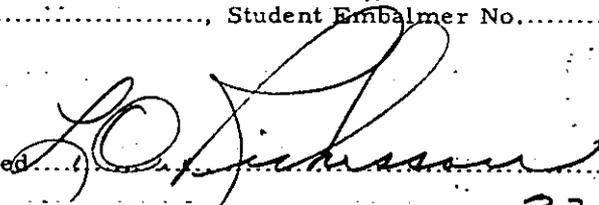
OCT 25 1957
JAN 22 1958

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. 330

P. O. Address Gallatin

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.