

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7909

STATE FILE NUMBER

FILED MAR 25 1957

Registration District No. 53 Primary Registration District No. 3009 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Cape Gir.</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jackson</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Jackson 01610</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>120 Hope St.</b>			Length of stay in 1b <b>7</b>		d. STREET ADDRESS (If outside, give location) <b>120 Hope St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Mae</b> Last <b>Deck</b>				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1880</b>		9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Jackson Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joseph Call</b>				14. MOTHER'S MAIDEN NAME <b>Mary Crump</b>				
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>unk</b>		17. INFORMANT <b>Mrs. Pat H. Summers</b>		Address <b>Jackson, Mo.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cerebra Arteriosclerosis</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) _____							INTERVAL BETWEEN ONSET AND DEATH <b>18 mos</b> <b>12 yrs</b>	
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 <b>Jan 8, 1957</b> to <b>Mar 13, 1957</b> and last saw her <sup>her</sup> <del>him</del> alive on <b>Feb 3, 1957</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>J. N. Jager MD</b>				22b. ADDRESS <b>Jackson Mo</b>		22c. DATE SIGNED <b>3-19-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-14-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Russell-Heights</b>		23d. LOCATION (City, town, or county) (State) <b>Jackson Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Alphacraft Jackson Mo</b>			25. DATE RECD. BY LOCAL REG. <b>3-20-57</b>		26. REGISTRAR'S SIGNATURE <b>C. C. Summers</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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Doctor, printer, etc. must use only standard non-removable ink. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Gene C. Crawford*.....

Licensed Embalmer No. *43*

P. O. Address *Jackson*

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.