

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31949

STATE FILE NUMBER

FILED SEP 24 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4085

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MISSOURI COUNTY JACKSON		
-b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1215 MICHIGAN 4 YRS		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1215 MICHIGAN		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARY LEE Jackson			4. DATE OF DEATH 8 30 1957		
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 12, 1931		9. AGE (In years last birthday) 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID		10b. KIND OF BUSINESS OR INDUSTRY HOMES		11. BIRTHPLACE (City and state or country) SCOTTVILLE, ARK	
13. FATHER'S NAME JOHN JACKSON			14. MOTHER'S MAIDEN NAME MINNIE SULLIVAN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, if unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT BEATRICE WALKER 1624 FOREST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Gastro-Enteritis 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)					INTERVAL BETWEEN ONSET AND DEATH 5711
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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Deputy Coroner			22b. ADDRESS 1618 Lydia Ave.		22c. DATE SIGNED 8/31/57
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 9-3-'57	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) No. LITTLE ROCK, ARK.
24. FUNERAL DIRECTOR BROWN-HUDSON		ADDRESS K.C., MO.		25. DATE RECD. BY LOCAL REG. 9-1-57	26. REGISTRAR'S SIGNATURE neva merrill

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-56
All deaths, coronary, 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

L. M. Tillman

2
63

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..... *John R. Dedmon*
Licensed Embalmer No. 45

P. O. Address *James City*

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.