

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37062

STATE FILE NUMBER

FILED NOV 14 1957

Registration District No. 314 Primary Registration District No. 4060 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>ST CLAIR</u>			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST CLAIR</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Roscoe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Roscoe</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		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>-</u> Last <u>Jackson</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 4. 1916</u>	9. AGE (In years last birthday) <u>41</u>	10. UNDER 1 YEAR Months <u>8</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FORNER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Collins Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>William Jackson</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Black</u>		14. NAME OF HUSBAND OR WIFE <u>-</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-07-0032</u>	17. INFORMANT Address <u>Addie Williams, Roscoe MI</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>Hypostatic pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fracture left femur</u>					<u>8 weeks</u>
DUE TO (c) <u>9040 21</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension of unknown duration</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>(preceding death) - fell at home</u>			
20c. TIME OF INJURY Hour <u>10:30 PM</u> Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Roscoe, St Clair Co., Missouri</u>		STATE <u>MO</u>	
21. I attended the deceased from <u>5-14-57</u> to <u>10-19-57</u> and last saw <u>him</u> alive on <u>10-19-57</u> Death occurred at <u>10:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>H. L. Chapman, D.O.</u> (Degree or title)			22b. ADDRESS <u>Osceola, Missouri</u>		22c. DATE SIGNED <u>10-20-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-22-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BENTON GREEN</u>		23d. LOCATION (City, town, or county) (State) <u>Roscoe MO</u>	
24. FUNERAL DIRECTOR <u>Goodrich & Home</u>		ADDRESS <u>OSCEOLA</u>		25. DATE RECD. BY LOCAL REG. <u>10-22-57</u>	26. REGISTRAR'S SIGNATURE <u>Paul S. Severn</u>

(Licensed Embalmer's Statement on Reverse Side)

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.

from query
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

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 J. B. Bradwell

Licensed Embalmer No. 3038

P. O. Address Osceola, N.

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.