

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008921

STATE FILE NUMBER

385

FILED APR 15 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

Health, Welfare, Public Service

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|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew MO-20</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>SAVANNAH</u> | | Inside Limits <input type="checkbox"/> <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u> | | Length of stay in lb <u>9 days</u> | d. STREET ADDRESS (If outside, give location) <u>RURAL</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Lee</u> Last <u>JACKSON</u> | | | 4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1958</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>Sept 24-1887</u> | 9. AGE (In years last birthday) <u>70</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 | 11. BIRTHPLACE (City and state or country) <u>Holt Co mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> |
| 13a. FATHER'S NAME <u>FRANK JACKSON</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sarah Wilson</u> | | 14. NAME OF HUSBAND OR WIFE <u>BERTHA JACKSON</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>none</u> | | 17. INFORMANT Address <u>Mrs Bertha Jackson Savannah mo</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>Pulmonary Insufficiency with right heart failure</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>months</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Interstitial pulmonary fibrosis</u> | | | | | <u>years</u> |
| DUE TO (c) <u>Pulmonary emphysema (obstructive)</u> | | | | | <u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5271</u> | | | | | 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.) <u>2</u> | | |
| 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>1/22/57</u> to <u>4/4/58</u> and last saw her alive on <u>4/3/58</u> Death occurred at <u>9-25 Ave</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Royall Patten, Jr. M.D.</u> | | | 22b. ADDRESS <u>Phy. & Surg. Bldg. - St. Joseph, Mo.</u> | | 22c. DATE SIGNED <u>4/8/58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 23b. DATE <u>4-4-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gennett Lane</u> | | 23d. LOCATION (City, town, or county) (State) <u>near Savannah mo</u> |
| 24. FUNERAL DIRECTOR <u>Breit Funeral Home Savannah mo</u> | | | 25. DATE RECD. BY LOCAL REG. <u>April 10, 1958</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *E. C. Greif*

Licensed Embalmer No. *2653*
P. O. Address *Savannah*

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.