

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014252
State File No.

FILED APR 22 1958

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1605

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY OR TOWN Kansas City, | | c. CITY OR TOWN Kansas City, | |
| c. LENGTH OF STAY in this place 4 1/2 yrs | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION DOA Queen of the World Hosp. | | STREET ADDRESS (If rural, give location) 2719 Olive Street | |

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|-------------------------------------------------------------------|------------|-------------|-----------|----------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) Ruth Louise Jackson | a. (First) | b. (Middle) | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) March 25, 1958 |
|-------------------------------------------------------------------|------------|-------------|-----------|----------------------------------------------------------------|

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|-------------------------|----------------------------------|--------------------------------------------------------------------------|--------------------------------------|----------------------------------------------|---------------------------|-------------------------|--------------------------|-------------------------|
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 2-22-1897 | 9. AGE (In years last birthday) 61 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hours | IF UNDER 1 HRS. Min. |
|-------------------------|----------------------------------|--------------------------------------------------------------------------|--------------------------------------|----------------------------------------------|---------------------------|-------------------------|--------------------------|-------------------------|

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|-----------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) Leavenworth, Kansas | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Frank Terry | 13b. MOTHER'S MAIDEN NAME Belle Alexander | 14. NAME OF HUSBAND OR WIFE Labon Jackson |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No | 16. SOCIAL SECURITY NO. 497-28-8308 | 17. INFORMANT'S SIGNATURE OR NAME Labon Jackson, 2719 Olive, K.C. Mo. | ADDRESS |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Valvular Heart disease | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None | | 42 1/4 |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension | | |
| | | DUE TO (c) | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City, Missouri |
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|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|----------------------------|

22. I hereby certify that I attended the deceased from **1-14-** 1954, to **3-24-** 1958, that I last saw the deceased alive on **3-24-** 1958, and that death occurred at _____ m., from the causes and on the date stated above.

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|--------------------------------------------|-------------------|---------------------------------------------------|------------------------------------|
| 23a. SIGNATURE I. V. Miller M.D. | (Degree or title) | 23b. ADDRESS 211 Paseo-Kansas City, Mo. | 23c. DATE SIGNED 3-27-58 |
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|------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 3-29-1958 | 24c. NAME OF CEMETERY OR CREMATORY St Mary's Cemetery | 24d. LOCATION (City, town, or county) (State) Kansas City, Mo. |
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| DATE REC'D BY LOCAL REG. 3-28-58 | REGISTRAR'S SIGNATURE neva marshall | 25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Meek's Mortuary, K.C. Mo. | ADDRESS |
|--------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------|---------|

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 *Millard B. Pasquin*

Licensed Embalmer No. *5013*

P. O. Address *D.C., Md*

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.