

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028809  
STATE FILE NUMBER

FILED AUG 18 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 784

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> <u>0396</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 <b>St. Johns Hosp.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>2357 N. Lyon</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD F. JACKSON</b>			4. DATE OF DEATH Month Day Year <b>Aug. 7, 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 March 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Co. Employee Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
13a. FATHER'S NAME <b>Jacob Jackson</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</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>Unknown</b>	17. INFORMANT Address <b>Hospital Records</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>Heart failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary arteriosclerotic insufficiency</b>			<b>Unknown</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)			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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 <b>Springfield</b>	COUNTY STATE <b>Greene Mo.</b>
21. I attended the deceased from <b>Mar 10, '56</b> to <b>8-7-58</b> and last saw him <b>live on Aug. 6, '58</b> Death occurred at <b>2:07</b> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>A. P. Kelly M.D.</b> (Degree or title)		22b. ADDRESS <b>609 Cherry Springfield, Missouri</b>	22c. DATE SIGNED <b>8-7-58</b>
23a. BURIAL, CREMATION, or other (Specify) <b>Burial</b>	23b. DATE <b>8-11-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hazelwood</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
24. FUNERAL DIRECTOR <b>J. Klingner &amp; Co.</b>		25. DATE RECD. BY LOCAL REG. <b>8-11-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie H. Melton</b>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

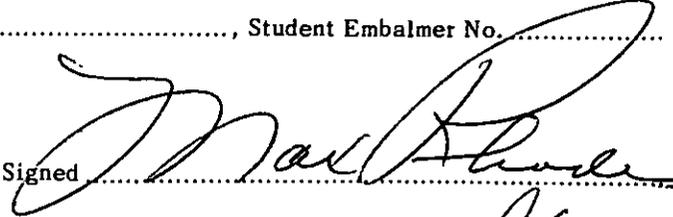
MEDICAL CERTIFICATION

George ...  
 Springfield ...  
 2257 ...  
 1928 ...  
 2 March 1878 ...  
 Retired ...  
 Decayed ...  
 No ...

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 

Licensed Embalmer No. 4071  
 P. O. Address .....

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.