

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032746  
STATE FILE NUMBER  
4060

FILED SEP 16 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		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. Luke's</b>		Length of stay in lb <b>47 yrs</b>	d. STREET ADDRESS <b>3524 Hunter Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>CHARLOTTA</b> Last <b>JACKMAN</b>			4. DATE OF DEATH Month <b>8</b> Day <b>23</b> Year <b>58</b>		
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-1894</b>	9. AGE (In years last birthday) <b>64</b>	FUNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Helsingborg, Sweden 4</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Seven P. Johnson</b>		13b. MOTHER'S MAIDEN NAME <b>Hilda Ronnberg</b>		14. NAME OF HUSBAND OR WIFE <b>Carl J. Jackman, Sr.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No xx</b>		16. SOCIAL SECURITY NO. <b>495-03-3629B</b>	17. INFORMANT Address <b>Carl J. Jackman, 3524 Hunter Rd.</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>Ruptured duod. ulcer</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>metastatic CA breast - removed 1942 -</b>					
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 WORK <input type="checkbox"/> 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 <b>5 July 1949</b> to <b>23 Aug 1958</b> and last saw her alive on <b>23 Aug 58</b> Death occurred at <b>9:30 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Of free or title) <i>Blaine Z. Hibbard</i>			22b. ADDRESS <b>411 Nichols Rd. KCMO</b>		22c. DATE SIGNED <b>25 Aug 58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-26-58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cem.</b>	
				23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Wagner Funeral Home, K. C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>8-25-58</b>		26. REGISTRAR'S SIGNATURE <i>Melva Minshall</i>

All diseases in Part I must be causally related. No symptoms will be listed.

MEDICAL CERTIFICATION  
Blaine Z. Hibbard, USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE



VA 1-4350

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 *Alvin R. Haunschild*

Licensed Embalmer No. *4159*

P. O. Address *K. C. Mo*

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.