

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035538
STATE FILE NUMBER

FILED NOV 10 1958

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1197

S. 300
v. 1-57

3

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

| | | | | | |
|--|---------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrew | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Joseph | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Mo. Methodist Hosp. | | Length of stay in 1b 16 yrs | d. STREET ADDRESS (If outside, give location) 0020 R.R. #2 Box 185 | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last ROY HARVE JACKSON | | | 4. DATE OF DEATH Month Day Year NOV. 5 1958 | | |
| 5. SEX Male <input checked="" type="checkbox"/> | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-14-1914 | | 9. AGE (In years last birthday) 44 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer | | 10b. KIND OF BUSINESS OR INDUSTRY Industrial Paper Co. | | 11. BIRTHPLACE (City and state or country) Stanberry Missouri | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13a. FATHER'S NAME Harge H. Jackson | | 13b. MOTHER'S MAIDEN NAME Lucy Adam | | 14. NAME OF HUSBAND OR WIFE None | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 495-01-8576 | | 17. INFORMANT Address Mrs. Myrtle Wilson R. R. #2 St. Joseph, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Renal Disease | | | | | INTERVAL BETWEEN ONSET AND DEATH Ukn. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) Diabetes | | | | | 442 X |
| 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 COUNTY STATE | |
| 21. I attended the deceased from 9-2-55 to 11-5-58 and last saw ^{her} him alive on 11-3-58 Death occurred at 12:15P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE A. W. Craig MD | | | 22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo. | | 22c. DATE SIGNED 11/5/58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-8-58 | 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Joseph Missouri |
| 24. FUNERAL DIRECTOR Hamer Funeral Home | | ADDRESS St. Joseph, Mo. | | 25. DATE RECD. BY LOCAL REG. Nov. 6, 1958 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell |

(Licensed Embalmer's Statement on Reverse Side)

Dr. Owen

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 Charles E. Bennett

Licensed Embalmer No. 74677

P. O. Address St. Joseph

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.