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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001127  
STATE FILE NUMBER

FILED JAN 6 1959

Registration District No. 139 Primary Registration District No. Registrar's No. 1

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|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HOLT</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>HOLT</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>OREGON</b>                       |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>MOUND CITY</b> c448   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BROWNE NURSING Hm.</b> |  | Length of stay in lb <b>4 yrs</b>   | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>GRANT ULYSSES JACKSON</b> |  |  | 4. DATE OF DEATH Month Day Year<br><b>JAN. 2, 1959</b> |  |  |
|---|--|--|--|--|--|

|                    |                               |   |                                       |                                      |                                |                                 |
|--------------------|-------------------------------|---|---------------------------------------|--------------------------------------|--------------------------------|---------------------------------|
| 5. SEX <b>MALE</b> | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>NOV. 20, 1871</b> | 9. AGE (In years birthday) <b>87</b> | 10. F UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
|--------------------|-------------------------------|---|---------------------------------------|--------------------------------------|--------------------------------|---------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b> | 11. BIRTHPLACE (City and state or country) <b>LEXINGTON, KENTUCKY</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
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|-----------------------------------|--|---|
| 13a. FATHER'S NAME <b>UNKNOWN</b> | 13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b> | 14. NAME OF HUSBAND OR WIFE <b>MOLLIE JACKSON</b> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES SPANISH-AM WAR</b> | 16. SOCIAL SECURITY NO. <b>UNKNOWN</b> | 17. INFORMANT Address <b>EARL JUDY - MOUND CITY MO.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CANCER OF RECTUM</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS.</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) _____                     |  |   |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>154X</b> |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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.) |
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|--|--|--|---|
| 20c. TIME OF INJURY Hour Month, Day, Year<br>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 |
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| 21. I attended the deceased from <b>4/1/55</b> , to <b>1/2/59</b> , and last saw her alive on <b>12/28/58</b> .<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |
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|  |                                |                                |
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| 22a. SIGNATURE (Degree or title) <b>H. E. Cobbin A.D. D.</b> | 22b. ADDRESS <b>oregon mo.</b> | 22c. DATE SIGNED <b>1/2/59</b> |
|--|--------------------------------|--------------------------------|

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|---|---------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> | 23b. DATE <b>1/4/1959</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>New Liberty Cem.</b> | 23d. LOCATION (City, town, or county) (State) <b>HOLT County, Mo.</b> |
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| 24. FUNERAL DIRECTOR ADDRESS <b>James Crawford, Mound City, Mo.</b> | 25. DATE RECD. BY LOCAL REG. <b>1/2/1959</b> | 26. REGISTRAR'S SIGNATURE <b>James Crawford</b> |
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(Licensed Embalmer's Statement of Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 26 1959

JAN 19 1959

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 *James H. Crawford* .....  
Licensed Embalmer No. *4796* .....  
P. O. Address *Mound City* .....

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.