

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005625

STATE FILE NUMBER

FILED FEB 17 1959

Registration District No. 149 Primary Registration District No. 10.02 Registrar's No. 487

300
-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY WYANDOTTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY 8150 7
c. FULL NAME OF HOSPITAL OR INSTITUTION (If not hospital, give location) 27th & Brooklyn		Length of stay in lb at work	d. STREET ADDRESS (If outside, give location) 34 North 10th St
3. NAME OF DECEASED (Type or print) First JOHN Middle W. JACKS Last			4. DATE OF DEATH Month Jan. Day 26, Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 28, 1897
9. AGE (In years last birthday) 61		IF UNDER 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) salesman driver		10b. KIND OF BUSINESS OR INDUSTRY Bread Co.	11. BIRTHPLACE (City and state or country) Drexel, Mo
12. CITIZEN OF WHAT COUNTRY? USA		13. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Jessie Jacks		13b. MOTHER'S MAIDEN NAME Rebecca Groves	
14. NAME OF HUSBAND OR WIFE Leona C. Jacks		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW I	
16. SOCIAL SECURITY NO. 495-09-1672		17. INFORMANT Address Mrs Leona C. Jacks 34 N. 10th K.C.Ks	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary Atherosclerosis</i> DUE TO (c) <i>Generalized arterio sclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes Mellitus (Insulin Dependent)</i>			INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> <i>undetermined</i> <i>undetermined</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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	
21. I attended the deceased from Death occurred at <i>12-7-58</i> to <i>1-14-59</i> and last saw her alive on <i>1-14-59</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Laurence L. Hayes MD</i>		22b. ADDRESS Hiway 169 & Barry Rd	
22c. DATE SIGNED 1/26/59		23. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1/28/59	
23c. LOCATION (City, town, or county) K.C.Mo.		(State)	
24. FUNERAL DIRECTOR Sebbeto Funeral Home		ADDRESS K.C.Mo.	
25. DATE RECD. BY LOCAL REG. 1-26-59		26. REGISTRAR'S SIGNATURE <i>Leona Trishall</i>	

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Laurence L. Hayes

All diseases in Part I must be causally related.

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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Forrest D. Goldman*

Licensed Embalmer No. *4714*

P. O. Address *K.P. 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.