

Health,  
& Welfare  
Public  
Service

S. 300  
1-57

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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-029941  
STATE FILE NUMBER

FILED VS SEP 9 1959

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY <i>Pemiscot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <i>Mo.</i> b. COUNTY <i>Pemiscot</i>	
b. CITY (If outside corporate limits - TOWNSHIP only) OR TOWN <i>Hayti</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Hayti</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS <i>504 W. Washington</i>
3. NAME OF DECEASED (Type or print) First <i>Ellie</i> Middle <i>B.</i> Last <i>Jackson</i>			4. DATE OF DEATH Month <i>Sept.</i> Day <i>2</i> Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-30-1919</i>
9. AGE (In years and birthday) <i>43</i>		10. F UNDER 1 YEAR Months <i>0</i> Yrs <i>3</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <i>housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>in home</i>	11. BIRTHPLACE (City and state or country) <i>Blytheville, Ark.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13a. FATHER'S NAME <i>Sam Jones</i>	
13b. MOTHER'S MAIDEN NAME <i>Mary Williams</i>		14. NAME OF HUSBAND OR WIFE <i>Albert Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>David Holmes, Hayti, Mo</i>
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>① lymphococci, type unspecified</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>② myocardial infarction generalized</i>			<i>2 wks.</i>
DUE TO (c) <i>due to unknown causes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>2021</i>			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 <i></i> Month, Day, Year <i></i> a.m. <i></i> p.m. <i></i>			
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 <i>Aug 1, 1959</i> to <i>Aug. 30, 1959</i> and last saw her alive on <i>Aug. 30, 1959</i> Death occurred at <i>11:30 a</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Orlilney M.D.</i>		22b. ADDRESS <i>200 + Hayti Mo</i>	22c. DATE SIGNED <i>9-8-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9-2-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Morgan</i>	23d. LOCATION (City, town, or county) (State) <i>Hayti, Mo.</i>
24. FUNERAL DIRECTOR <i>T. J. Smith Hayti, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>9-2-59</i>	26. REGISTRAR'S SIGNATURE <i>Lashonda Adams</i>

(Licensed Embalmer's Statement on Reverse Side)

8 1959

*Max*

*Embalmers*

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.....

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.