

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031837

FILED VS OCT 6 1959

Registration District No. 2 Primary Registration District No. 3017 Registrar's No. 139

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>CODPER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>CODPER</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>BOONVILLE</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>BOONVILLE</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			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>104. BELL ST</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>-</b> Last <b>JACKSON</b>				4. DATE OF DEATH Month <b>SEPT</b> Day <b>24</b> Year <b>59</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</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>OCT. 10. 1874</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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		11. BIRTHPLACE (City and state or country) <b>BOONVILLE MO</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>JOHN - JACKSON</b>			13b. MOTHER'S MAIDEN NAME <b>JANE TURNER</b>			14. NAME OF HUSBAND OR WIFE <b>EMMA - JACKSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <b>RODGER JACKSON 104. BELL ST</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>Cerebral Vascular Accident - site undetermined</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ a.m. _____ p.m. _____		Month, Day, Year _____							
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 <b>Beach on arrival</b> and last saw her him alive on <b>D.O.A.</b> Death occurred at <b>8:40 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>William C. Chik MD</b>				22b. ADDRESS <b>329 Main St Boonville Mo.</b>				22c. DATE SIGNED <b>9-28-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>SEPT. 18. 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CITY</b>		23d. LOCATION (City, town, or county) <b>BOONVILLE MO</b>		(State)		
24. FUNERAL DIRECTOR <b>H. MAY</b>				ADDRESS <b>814 S. PORTER ST</b>		25. DATE RECD. BY LOCAL REG. <b>9/28/59</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DOCUMENT

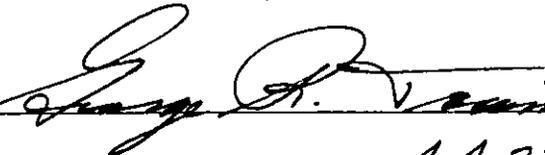
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 442

P. O. Address Columbus, Ga.

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.