

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034870

FILED VS OCT 13 1959

STATE FILE NUMBER

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 7

ENDED

1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Saline				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Slater		Length of stay in 1b 35 yrs		c. CITY OR TOWN Slater		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 209 E. Emma			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 209 E. Emma		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alfred Middle (None) Last Jackson				4. DATE OF DEATH Month October Day 3 Year 1959				
5. SEX Male	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 7-14-1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Glasgow, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Alfred Jackson			13b. MOTHER'S MAIDEN NAME Marietta Wallace			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) None			16. SOCIAL SECURITY NO. 709-10-9038		17. INFORMANT Address Miss Lucinda Jackson Slater, 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) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Atrial fibrillation</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
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 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 <u>Sept 3-59</u> to <u>Oct 2-59</u> and last saw ^{her} him alive on <u>Oct 2-59</u> Death occurred at <u>S.A.H.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J. Wilson</u> (Degree or title)				22b. ADDRESS <u>313 1/2 W. Main Slater</u>				22c. DATE SIGNED <u>10-3-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-5-1959	23c. NAME OF CEMETERY OR CREMATORY City		23d. LOCATION (City, town, or county) Slater, Missouri		(State)	
24. FUNERAL DIRECTOR Haines Funeral Home Slater, Mo.				25. DATE RECD. BY LOCAL REG. Oct. 4, 1959		26. REGISTRAR'S SIGNATURE <u>Geo. Raymond Braine</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS OCT 14 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 *Ray F. Hayes Jr*

Licensed Embalmer No. 4630

P. O. Address Slater, 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.