

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040649

FILED VS NOV 30 1959 157

Registration District No. _____ Primary Registration District No. 3028 Registrar's No. 219

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Jasper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in 1b 22 yrs		c. CITY OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 602 Valley		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last LOTTIE JACKSON				4. DATE OF DEATH Month Day Year Nov. 16, 1959			
5. SEX female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-4-86	9. AGE (last birthday) 73	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) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and state or country) West Plains, Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Henry Farrar			13b. MOTHER'S MAIDEN NAME Dinah Campbell		14. NAME OF HUSBAND OR WIFE Jessie Jackson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Carthage, Mo Jessie Jackson, 602 Valley			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into Pericardial Sac DUE TO (b) Rupture of aneurism of ascend- DUE TO (c) my aorta Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension 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							INTERVAL BETWEEN ONSET AND DEATH 2 days
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 Nov 14, 59 to 11-16-59 and last saw her alive on 11-16-59 Death occurred at 12:35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) George H. Wood M.D.				22b. ADDRESS 304 Grant, Carthage, Mo			22c. DATE SIGNED 11-16-59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11-19-59	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) Carthage, Mo		23e. STATE	
24. FUNERAL DIRECTOR ADDRESS KNELL MORTUARY Carthage, Mo			25. DATE RECD. BY LOCAL REG. 11-17-59		26. REGISTRAR'S SIGNATURE [Signature]		

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Robert H Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

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.