

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 17 1960

60-013880

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 8151 Registrar's No. 26

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Flk Twpn</u>		Length of stay in 1b <u>1 year</u>		c. CITY OR TOWN <u>Parma</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3mi NW of Catron, Mo.</u>				d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Jackson</u> Last <u>Jackson</u>				4. DATE OF DEATH <u>February 24 1960</u> Month <u>February</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-92</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Holly Springs, Miss.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Cornelius Jackson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Cornelius Jackson, Parma, Mo.</u> Address			
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>Coronary Occlusion</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 <u>2-15-60</u> to <u>Feb 24, 1960</u> and last saw him alive on <u>Feb 15, 1960</u> Death occurred at <u>9 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. Geo. W. Hunter, M.D.</u>				22b. ADDRESS <u>Parma, Mo.</u>		22c. DATE SIGNED <u>3/5/60</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-28-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dexter Cemetery (Colored)</u>		23d. LOCATION (City, town, & county) <u>Dexter, Missouri</u>		
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>3/12/60</u>		26. REGISTRAR'S SIGNATURE <u>Velma V. Jamboree</u>	

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. 5030
P. O. Address Fillmore, Pa.

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.