

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**60-016195**

FILED VS MAY 5 1960

217

Primary Registration District No. 3045

Registrar's No. 28

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <b>MISSISSIPPI COUNTY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>MISSOURI</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CHARLESTON, MO.</b>		Length of stay in lb <b>25 yrs.</b>	c. CITY OR TOWN <b>CHARLESTON, MO.</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 <b>214 LAYAFETTE ST.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>214 LAYAFETTE ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>KATIE</b> Middle <b>ENOLA</b> Last <b>JACKSON</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-1892</b>	9. AGE (last birthday) <b>68</b>	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) <b>DOMESTIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (City and state or country) <b>PARAGOULD, ARKANSAS U.S.A</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
13a. FATHER'S NAME <b>JOHN RICHARD GOALDMAN</b>		13b. MOTHER'S MAIDEN NAME <b>CALLIE JENKINS</b>		14. NAME OF HUSBAND OR WIFE <b>LOUIS JACKSON</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHARLESTON, MO.</b> <b>MRS. OTHA MAYS CHARLESTON, MO.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>acute cardiac decompensation</i>		<i>1 week</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Hypertensive cardiovascular disease</i>	<i>5 yrs.</i>
	DUE TO (c) <i>anemia</i>	<i>3 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hemiplegia complete bed fast 5 yrs</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N: <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 <b>CHARLESTON, MO.</b>	COUNTY <b>MISSISSIPPI</b>	STATE <b>MO.</b>
21. I attended the deceased from <b>4-5-60</b> to <b>4-22-60</b> and last saw her alive on <b>4-21-60</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>Katie Enola Jackson</i> (Degree or title)		22b. ADDRESS <i>Charleston Mo</i>	22c. DATE SIGNED <b>4-26-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-24-.960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CITY CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>HICKMAN, KENTUCKY</b>

24. FUNERAL DIRECTOR <b>SHELBY FUNERAL HOME EAST PRAIRIE, MO.</b>	ADDRESS <b>EAST PRAIRIE, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>4-29-60</b>	26. REGISTRAR'S SIGNATURE <i>Dorothy B. Hawthorn</i>
--	-------------------------------------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

0961

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

*Travis Shelby*

Licensed Embalmer No. *4940*

P. O. Address *East Place*

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.