

**FEDERAL BUREAU OF INVESTIGATION
FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS SEP 6 1960

-60-031171

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 2035 Registrar's No. 78

ENDED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u> Length of stay in lb <u>1 week</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> c. CITY OR TOWN <u>Higginsville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>513 W. Broadway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PETER</u> Middle <u>STERLING</u> Last <u>JACKSON</u>			4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Pettis Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Frank Jackson</u>		13b. MOTHER'S MAIDEN NAME <u>Francis Wood</u>		14. NAME OF HUSBAND OR WIFE <u>Caroline M. Jackson, Dec.</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>500-14-3490</u>		17. INFORMANT Address <u>Neil Jackson (Son) Higginsville, Mo.</u>			
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>Cerebral Vascular Accident</u> DUE TO (b) <u>ACU Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>Yrs.</u>		
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 <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>		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 <u>Missouri</u> STATE			
21. I attended the deceased from <u>8-8-60</u> to <u>8-14-60</u> and last saw <u>him</u> alive on <u>8-14-60</u> Death occurred at <u>9:20</u> on <u>8-14-60</u> at <u> </u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert Best, M.D.</u> (Degree or title)			22b. ADDRESS <u>Higginsville, Mo.</u>		22c. DATE SIGNED <u>8/15/1960</u> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>			
24. FUNERAL DIRECTOR ADDRESS <u>A. H. Hader Funeral Home</u> <u>By <u> </u> Manager, Higginsville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-16-60</u>		26. REGISTRAR'S SIGNATURE <u> </u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 - 9 SEP SA

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 Leona Thurman

Licensed Embalmer No. 4563

P. O. Address Richmond, Va

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.