

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007267

STATE FILE NUMBER

AMENDED

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 4

FILED VS FEB 20 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Saline</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Slater</u>		Length of stay in lb. <u>Life</u>	c. CITY OR TOWN <u>Slater</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Emmerson St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Emmerson St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDA</u> Middle <u>(none)</u> Last <u>JACKSON</u>			4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negroe</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>2/12/1893</u>	9. AGE (last birthday) <u>68</u> 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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Slater, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Sniver</u>		13b. MOTHER'S MAIDEN NAME <u>Julie Miller</u>		14. NAME OF HUSBAND OR WIFE <u>Tommy 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 Address <u>Tommy Jackson, Slater, 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>Pulmonary congestion due to chr. myocarditis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years?</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)			DUE TO (c)	
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>Feb. 11, 1961</u> to <u>Feb. 12, 1961</u> and last saw her alive on <u>Feb. 11, 1961</u> Death occurred at <u>7:00 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>C.A. McBurney M.D.</u>			22b. ADDRESS <u>Slater, Mo.</u>		22c. DATE SIGNED <u>2/13/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/15/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Moriah</u>		23d. LOCATION (City, town, or county) (State) <u>Slater, Missouri</u>		
24. FUNERAL DIRECTOR <u>Haines Funeral Home, Slater, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-15-61</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Raymond Branne</u>		

**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 Guy F. Hays, Jr.

Licensed Embalmer No. 4630

P. O. Address Alatun, W

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.