

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008372
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 319A

AMENDED

FILED APR 10 1961

DATE AMENDED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield,</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Republic,</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Gertrude</u> Last <u>Jackson</u>	4. DATE OF DEATH Month <u>March</u> Day <u>27,</u> Year <u>1961</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>6-19-1983</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>8</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Bethel, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John. Wallace Finney</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Emily Neil</u>	14. NAME OF HUSBAND OR WIFE <u>Ferd Jackson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Ferd Jackson,</u> Address <u>Republic, Mo.</u>
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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)	<u>Cor Congestive Heart Failure</u>	<u>sev. weeks</u>
DUPLICATE (b)	<u>arterio sclerotic Heart Dis.</u>	<u>sev. yrs.</u>
DUPLICATE (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 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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <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 <u>Republic, Mo.</u>	COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from 1959 to Mar. 27 '61 and last saw her her alive on 3-27-61
Death occurred at 2:05 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>3-31-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 29, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wade Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Republic, Mo.</u>
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24. FUNERAL DIRECTOR <u>W.B. Cantrell</u>	ADDRESS <u>Republic, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-3-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 William B. Cantrell

Licensed Embalmer No. 4850

P. O. Address Republic Mo

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.