SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-010155
STATE FILE NUMBER

AMENDED

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 30

FILED MAR 30 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Pulaski
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cullen Tswp
Length of stay in 1b —
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt #1 Waynesville
Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Pulaski
c. CITY OR TOWN Waynesville
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Buckhorn
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Walter Middle: Greenleaf Last: Jackson
4. DATE OF DEATH Month: March Day: 14 Year: 1961
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 6/19/1881
9. AGE (last birthday) 79
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) Labor
10b. KIND OF BUSINESS OR INDUSTRY Commercial
11. BIRTHPLACE (City and state or country) Stark County Ill
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME James Jackson
13b. MOTHER'S MAIDEN NAME Mary J. Blanchard
14. NAME OF HUSBAND OR WIFE Addie Jackson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT James M. Blanchard Address Rt #1 Waynesville, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: INST
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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~~ _____ to _____ ~~and~~ last saw ~~her~~ him ~~alive on~~ 3/14/61
Death occurred at 8:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Clarence Moss (Degree or title) Coroner
22b. ADDRESS Waynesville, Mo
22c. DATE SIGNED 3/14/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3/16/1961
23c. NAME OF CEMETERY OR CREMATORY IDEUMA Cemetery
23d. LOCATION (City, town, or county) (State) Laquey Missouri
24. FUNERAL DIRECTOR Moss-Williams ADDRESS Waynesville, MO
25. DATE RECD. BY LOCAL REG. 3-15-61
26. REGISTRAR'S SIGNATURE Eula Inge Anderson

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Clarence Ross

Signature of Student Embalmer

Licensed Embalmer No. 4896

P. O. Address Waynesville, N

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.