SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-021906
STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 224

FILED JUL 5 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Hannibal — Length of stay in 1b: 16 yrs
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 1107 Lyon St — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Marion
c. CITY OR TOWN: Hannibal — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1107 Lyon St — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Josephine — Middle: — Last: Jackson

4. DATE OF DEATH: Month 6 – Day 22 – Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10-18-68
9. AGE (last birthday): 93 — 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): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Monticello, Mo.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Thomas Bugh
13b. MOTHER'S MAIDEN NAME: Aletha Walters
14. NAME OF HUSBAND OR WIFE: William 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.:
17. INFORMANT: William Jackson Jr. — Address: Hannibal, 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): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
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): Senility
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 May 3, 1960, to and last saw her/him alive on January 13, 1960.
Death occurred at 6:35 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert J. Lanning MD
22b. ADDRESS: Hannibal, Mo.
22c. DATE SIGNED:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-24-1961
23c. NAME OF CEMETERY OR CREMATORY: Lewistown Cemetery
23d. LOCATION (City, town, or county) (State): Lewistown, Mo.

24. FUNERAL DIRECTOR — ADDRESS: Clark Funeral Home – Hannibal, Mo.
25. DATE RECD. BY LOCAL REG.: 6-24-61
26. REGISTRAR'S SIGNATURE: Dr. E. M. Luck by Lillian M. Herman

(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_____
Signature of Student Embalmer

Signed Roger G. Clark

Licensed Embalmer No. 4217

P. O. Address Hannibal, 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.