

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032252
STATE FILE NUMBER

AMENDED

75
FILED SEP 20 1961 Primary Registration District No. 5300 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Platte Township</u>		Length of stay in 1b <u>3 years</u>	c. CITY OR TOWN <u>Platte Township</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>R. F. D. 2</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. F. D. 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>King</u> Last <u>Jackson</u>			4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1961</u>		
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>10/2/1874</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
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	11. BIRTHPLACE (City and state or country) <u>Clinton County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>

13a. FATHER'S NAME <u>William Bigaenstaff</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Hosea 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>Mrs. Dorothy Hoskins, Plattsburg, 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 Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>15 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephrotic Syndrome - 2 mo.</u>		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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <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> </u> STATE <u> </u>

21. I attended the deceased from Aug 1953 to Sept 7, 1961 and last saw her/him alive on Sept 6, 1961
Death occurred at 1:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

23a. SIGNATURE (Degree or title) <u>John P. Mabrey M.D.</u>		22b. ADDRESS <u>Plattsburg, Mo.</u>		22c. DATE SIGNED <u>9-8-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/9/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	23d. LOCATION (City, town, county) (State) <u>Plattsburg, Missouri</u>	

24. FUNERAL DIRECTOR <u>Lyon Funeral Home, Inc, Plattsburg, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 12 1961</u>	26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

 INSTEAD OF

 DOCUMENT

 MEDICAL CERTIFICATION

 SHOULD READ

 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 Phillip E. Cox

Licensed Embalmer No. 4993

P. O. Address Plant City, Fla.

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.