

Registration District No. 193

Primary Registration District No. 5728

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County MOdonald  
 (b) City or town Buffalo TWP.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Goodman MO R. # 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County MOdonald  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. Goodman MO R. # 1 (If rural, give location)  
 (e) Citizen of foreign country? NO. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LENORA JACKSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife J E JACKSON  
 6. (c) Age of husband or wife if alive 72 years  
 7. Birth date of deceased Aug 17th, 1876  
 (Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace IND (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name WYMAN ADAMS  
 13. Birthplace Unknown (City, town, or county) (State or foreign country)  
 14. Maiden name ANNA BOLES  
 15. Birthplace OHIO (City, town, or county) (State or foreign country)

16. (a) Informant J. E. Jackson  
 (b) Address Goodman MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Hewitt Cemetery

18. (a) Signature of funeral director Chas W. Williams  
 (b) Address Goodman MO.

19. (a) 3/1/44 (Date received local registrar) (b) Chas W. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1944 hour 9 minute 0, A. M.

21. I hereby certify that I attended the deceased from December 20th, 1941, to Feb 22, 1944

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure  
 Due to Hypertension  
 Due to pneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature Chas W. Williams (M. D. or other) \_\_\_\_\_  
 Address Goodman Mo Date signed 2-23-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

464

RECEIVED

District Health Officer No. 6,

District File Number 344-342

Date Filed MAR 16 1944

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, fact should be so stated above.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Mc Donald  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 30 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Lenora Jackson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex 7

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Aug. 17 (Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days \_\_\_\_\_ (if less than one day) min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 26 Year 1944 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL

SUPPLEMENTARY

INFORMATION

REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature C. James (M. D. or other) do.  
Address Goodman Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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