

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32421**

FILED OCT 30 1951

BIRTH NO. _____ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **285**

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Adair | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Grim-Smith Memorial | | d. STREET ADDRESS (If rural, give location) 1112 S. Franklin | |

| | | | | | |
|---|--|---|---|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Marshall b. (Middle) Guy c. (Last) Jackson | | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 19, 1951 | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro Colored | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | |
| 8. DATE OF BIRTH Oct. 5, 1887 | | 9. AGE (In years last birthday) 64 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repair Shop | |
| 11. BIRTHPLACE (State or foreign country) Dalton, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10b. KIND OF BUSINESS OR INDUSTRY Repairing Shoes | |

| | | | | | |
|--------------------------------------|--|---|--|---|--|
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Marie Jackson | |
|--------------------------------------|--|---|--|---|--|

| | | | | | |
|---|--|---|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. I. | | 16. SOCIAL SECURITY NO. 486-12-5978 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Marie Jackson, Kirksville, Mo | |
|---|--|---|--|--|--|

| | | | | | |
|--|--|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage Hypertension ANTECEDENT CAUSES Cardiovascular renal disease Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 21 DUE TO (c) 21 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs |
|--|--|---|--|--|--|

| | | | | | |
|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 442X | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from **Oct 19, 1951**, to **Oct 19, 1951**, that I last saw the deceased alive on **Oct. 19, 1951**, and that death occurred at **9:30 a.m.**, from the causes and on the date stated above.

| | | | | | |
|---|--|---|--|--|--|
| 23a. SIGNATURE (Degree or title) George E. Grim M.D. | | 23b. ADDRESS Kirksville, Missouri | | 23c. DATE SIGNED 10/20/51 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 10/22/51 | | 24c. NAME OF CEMETERY OR CREMATORY Llewellyn | |
| 24d. LOCATION (City, town, or county) (State) Kirksville, Mo. | | 25. FUNERAL DIRECTOR'S SIGNATURE Paul W. Ryan | | ADDRESS Kirksville, Mo. | |
| DATE REC'D BY LOCAL REG. 10-22-51 | | REGISTRAR'S SIGNATURE Kate Lambert | | | |

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

013
0

1951 9 10 17

Date Received: OCT 29 1951
DISTRICT HEALTH OFFICE #
District File Number 10-51-
Date Filed: OCT 29 1951

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
Student Embalmer

Signed *John C. Cooper*

Licensed Embalmer No. *4119*

P. O. Address *Starksville, 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 this body is not embalmed, fact should be so stated above.