

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004787

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

District No. 325 Primary Registration District No. 6098 Registrar's No. 100

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Schuyler</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lancaster</u> Length of stay in 1b _____</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Country</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Schuyler</u></p> <p>c. CITY OR TOWN <u>Downing</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>Country</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>David</u> Last <u>Jackson</u></p>		<p>4. DATE OF DEATH Month <u>1</u> Day <u>-18</u> Year <u>1963</u></p>				
<p>5. SEX <u>m</u></p>	<p>6. COLOR OR RACE <u>w.</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>11-5-1870</u></p>	<p>9. AGE (last birthday) <u>1-13-92yo.</u></p>	<p>IF UNDER 1 YEAR Months _____ Days _____</p>	<p>IF UNDER 24 HR Hours _____ Min. _____</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY _____</p>		<p>11. BIRTHPLACE (City and state or country) <u>Schuyler</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>George Jackson</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Ann Whitton</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>Ella Jackson</u></p>		
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) _____</p>		<p>16. SOCIAL SECURITY NO. _____</p>		<p>17. INFORMANT Address <u>5740 Mrs Harold Burns Lancaster</u></p>		
<p>18. CAUSE OF DEATH (Enter only one cause)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Circulatory failure</u></p> <p style="text-align: center;">DUE TO (b) <u>Congenital heart failure</u></p> <p style="text-align: center;">DUE TO (c) <u>Extreme age and myocardial damage</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Tobac pneumonia in Nov. 1962</u></p> <p>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</p>						
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p>		
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		
<p>20f. CITY, TOWN, OR LOCATION _____</p>		<p>COUNTY _____</p>		<p>STATE _____</p>		
<p>21. I attended the deceased from <u>5-3-58</u> to <u>1-18-63</u> and last saw <sup>her</sup> him alive on _____</p> <p>Death occurred at <u>9.05 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>						
<p>22a. SIGNATURE (Degree or title) <u>H.R. Stokes M.D.</u></p>		<p>22b. ADDRESS <u>Lancaster Mo.</u></p>		<p>22c. DATE SIGNED <u>1-22-63</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>Jan 21-63</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Downing</u></p>		
<p>23d. LOCATION (City, town, or county) <u>Downing</u></p>		<p>(State) <u>MO</u></p>		<p>24. FUNERAL DIRECTOR <u>Bertz &amp; Bassett Memphis TN</u></p>		
<p>25. DATE RECD. BY LOCAL REG. <u>Jan. 24, 1963</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Flarence Shepherd</u></p>				

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

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*Permit obtained pending completion*

**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 George Guth

Licensed Embalmer No. 5091

P. O. Address Memphis, 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.