

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Texas b. COUNTY Hill	
b. CITY OR TOWN (If outside city limits, give precinct no.) Cleburne		c. LENGTH OF STAY in 1 b. days	
d. NAME OF (If not in hospital, give street address) HOSPITAL OR INSTITUTION Johnson Co. Memorial Hospital		d. STREET ADDRESS (If rural, give location) Blum	
a. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		a. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) a) First George b) Middle Christopher c) Last Jackson	
4. DATE OF DEATH November 26, 1972		5. SEX Male	
6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 1-2-1882		9. AGE (In years last birthday) 90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rancher		10b. KIND OF BUSINESS OR INDUSTRY Ranching	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME G.R. Jackson		14. MOTHER'S MAIDEN NAME Ellen Gouger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 167-74-3254	
17. INFORMANT Mrs. George C. Jackson (Wife)		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) TERMINAL DISEASE CAUSED BY HEALTH IMMEDIATE CAUSE (a) A-S-H-O - resultant Cerebrovascular Hemorrhage DUE TO (b) BUREAU OF VITAL STATISTICS REC'D JAN 3, 1973			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	
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 building, etc.)	
20f. CITY, TOWN, OR LOCATION Blum		20g. COUNTY Blum	
20h. STATE Texas		21. I hereby certify that I attended the deceased from 5-22-67 , 19____ to 11-26-72 , 19____ and last saw the deceased alive on 11-26-72 , 19____. Death occurred at 3:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE [Signature]		22b. ADDRESS 310 W. Chambers Cleburne, Texas	
22c. DATE SIGNED 11-30-72		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 11-27-1972		23c. NAME OF CEMETERY OR CREMATORY Blum Cemetery	
23d. LOCATION (City, town, or county) Blum Texas		24. FUNERAL DIRECTOR'S SIGNATURE [Signature] Crosier-Pearson Funeral Home By: A.W. Snider	
25a. REGISTRAR'S FILE NO. 9184		25b. DATE REC'D BY LOCAL REGISTRAR 12/7/72	
25c. REGISTRAR'S SIGNATURE [Signature]			

TEXAS DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATION

VS-12, REV. 1/58