WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Pettis

Township Smithton

or

Village

or

City (NO. St.; Ward)

Registration District No. 669 File No. 22198

Primary Registration District No. 5892 Registered No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Evilina Jackson

PERSONAL AND STATISTICAL PARTICULARS

SEX P

COLOR OR RACE Colon

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH Dont Known, 1826 (Month) (Day) (Year)

AGE 90 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 22 17

BIRTHPLACE (City or town, State or foreign country) Ken.

PARENTS

NAME OF FATHER Un Known

BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W H Jackson

(ADDRESS) Sedalia Mo

Filed June 2, 1916. S. M. Parnsle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 10 (Day), 191 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 29, 1916, to May 7, 1916, that I last saw her alive on May 7, 1916, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cause unknown no position
Diagnosis but symptoms
resembled Apoplexy

(Duration) yrs. mos. ds.

64

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) S. M. Parnsle M. D.

June 2, 1916 (Address) Smithton

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Pearson

DATE OF BURIAL 5-12- 1916

UNDERTAKER McLaughlin

ADDRESS Bros,

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) 1 _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
- NAME OF FATHER _____
- BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
- MAIDEN NAME OF MOTHER _____
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____ 191__ _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS