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.

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

PLACE OF DEATH

County Montgomery

Township Prairie
or
Village
or
City (NO. , St.; Ward)

Registration District No. 591 File No. 9393

Primary Registration District No. 5789 Registered No. 9

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

FULL NAME Bulah Ann Jackson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE Negro

SINGLE MARRIED WIDOWED OR DIVORCED (Write Name) Married

DATE OF BIRTH Jan (Month) 12 (Day), 1893 (Year)

AGE 26 yrs. 2 mos. 1 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 23

BIRTHPLACE (City or town, State or foreign country) Middletown Mo

PARENTS
NAME OF FATHER M Shepherd
BIRTHPLACE OF FATHER (City or town, State or foreign country) Middletown Mo
MAIDEN NAME OF MOTHER Martha Carter
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pike Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Jackson

(ADDRESS) Fanning Mo

Filed March 14 1918. C. H. Rigg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mch (Month) 13 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 28, 1917, to Mch 13, 1918, that I last saw her alive on Mch 11, 1918, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of 28 Lungs

(Duration) ✓ yrs. 5 mos. ✓ ds.

Contributory (SECONDARY) ✓

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) C. F. Eckins M. D.

2/13, 1918 (Address) Fanning Mo

*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 Middletown Mo

DATE OF BURIAL Mch 14 1918

UNDERTAKER Chas. S. Murphy

ADDRESS Bellflower

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

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

PLACE OF DEATH

County.....

Township ..... or Village..... or City .....(NO..... .....St.:.....Ward)

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

[If death occurred i hospital or instituti give its NAME inst 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

....., 1.....
(Month) (Day) (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

....., 191..
(Month) (Day) (Yea

I HEREBY CERTIFY, that I attended deceased fr ....., 191...., to....., 191... that I last saw h.....alive on....., 191... and that death occurred, on the date stated above, at..... The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed)..... M.

....., 191..... (Address).....

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

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

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

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