

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

Do not use this space.

1352

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Ball Primary Registration District No. 816 1/2 Jefferson  
 City Kansas No. 816 1/2 Jefferson St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 399  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Annie E. Jackson  
 (a) Residence No. 816 1/2 Jefferson St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Fe 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 11, 1887  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 39 7 13

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Seamstress  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Texas

10. NAME OF FATHER John Nelson Foster

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Texas

12. MAIDEN NAME OF MOTHER Lucille Mason

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Texas

14. INFORMANT Maisy Jackson (Address) 1108 1/2 Highland

15. FILED Jan 28, 1927 M. D. N. Crowe REGISTRAR Wesley

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/24 1927  
 17. I HEREBY CERTIFY That I attended deceased from 6-10 1926 to 1-24 1927 that I last saw her alive on 1-24 1927, and that death occurred, on the date stated above, at 10:45 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Tuberculosis  
23A  
110K  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
**CONTRIBUTORY (SECONDARY)** Pleurisy  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
 (Signed) C. H. Deane M. D.

1/25 1927 (Address) 1523 E 18th St. Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Ridge Lawn DATE OF BURIAL 1/29 1927

20. UNDERTAKER Mathias Bros ADDRESS 1729 Lydia

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.

E. A. Walker.