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

Do not use this space.

File No. 27072

Registered No. 18

1. PLACE OF DEATH

County: Howard

Township: Franklin

City: ..... (No. ..... St. ..... Ward)

Registration District No. 380

Primary Registration District No. 5530

2. FULL NAME Jennie H. Jackson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. ~~Married, Married, Widowed or Divorced~~ (write the word): Widowed

5a. If ~~Married, Widowed, or Divorced~~ ~~Married or~~ (or) WIFE OF: George Jackson

6. DATE OF BIRTH (Month, day and year): Jan. 10th 1851

7. AGE: Years 76 | Months 8 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (City or town): Virginia
(State or country)

PARENTS

10. NAME OF FATHER: Coleman Wells

11. BIRTHPLACE OF FATHER (City or town): .....
(State or country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Wells

13. BIRTHPLACE OF MOTHER (City or town): .....
(State or country): Virginia

14. INFORMANT: Bob Powell
(Address): Fayette, Mo.

15. FILED 9-29-1927 B Fleet REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month, day and year): 9-28 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1927, to Sept 27, 1927, that I last saw her alive on Sept. 27, 1927, and that death occurred, on the date stated above, at 9 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cer. Apoplexy
8 hrs
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY): Hemiplegia
(duration) ..... yrs. ..... mos. 8 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? None
(Signed) B Fleet, M. D.
9-29-1927 (Address) New Franklin, 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: Mount Pleasant, | DATE OF BURIAL: 9 29 27

20. UNDERTAKER: Guy T. Halley. | ADDRESS: Fayette, Mo.

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.