

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

Do not use this space.

30497

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 300A  
 Township Kear Primary Registration District No. 1007 Registered No. 300A  
 City Kansas City (No. 2541) Woodland St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Ellen Jackson  
 (a) Residence. No. 2541 Woodland St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 10 yrs. 7 mos. 11 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Tom Jackson  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 11, 1867  
 7. AGE YEARS 60 MONTHS 6 DAYS 11 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

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

10. NAME OF FATHER Frank Lawson

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Phelps J. Adams (Address) 2541 Woodland

15. FILED 10/24/27 M. M. Crow REGISTRAR Arca

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 18, 1927  
 17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to 10-18-27 and that I last saw her alive on Oct 18, 1927 and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Haemorrhage  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY Mitral Regurgitation (SECONDARY) (duration) 1 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? Chromic  
 (Signed) Superintendent (Address) 1922 15th St. 531 Dept.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Highland DATE OF BURIAL Oct. 24, 1927

20. UNDERTAKER Adkins Bros ADDRESS 2127 Vine

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.

531 10/12/20