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

Do not use this space.

32625

1. PLACE OF DEATH
County Audrain
Township
City Mexico (No. St. Ward)
Registration District No. 26 Dr. Williams
Primary Registration District No. 3002
File No.
Registered No. 157

2. FULL NAME Mrs. Alice (Green) 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.

AN 3 1928

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ ~~(OR)~~ WIFE OF Green Jackson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 1 – 1882

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
45	10	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(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) Calloway Co. Mo.

PARENTS
10. NAME OF FATHER Emanuel Nickens
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Calloway Co. Mo.
12. MAIDEN NAME OF MOTHER X
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) X

14. INFORMANT Green Jackson
(Address) Mexico Mo.

15. FILED Nov 18th 1927 Ira S. Milligan REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 17 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1927, to Nov. 17, 1927 that I last saw her alive on Nov. 17, 1927, and that death occurred, on the date stated above, at 1 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular disease cardiac chr.
myocarditis
92 A Myositis Parenchymatous
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) arteriosclerosis
(duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) R. S. Williams, M. D
, 19 (Address) Mexico 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 Mexico Mo.
DATE OF BURIAL Nov. 20 1927

20. UNDERTAKER McPhaetus Bros
ADDRESS Mexico Mo.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NO[illegible] [illegible]EC[illegible] A FEE FOR CERTIFICATES [illegible]ED BY LAW

1. PLACE OF DEATH.

County Audrain Registration District No. 26 File No. .....

Township ..... Primary Registration District No. 3002 Registered No. 157

City Mexico (No. ....., ... St. ..... Ward)

2. FULL NAME Alice (Green) 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	B	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	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) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT .....
(Address)

15. FILED Nov 18 1927 Ira S. Millignon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 17 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-32625