

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

Do not use this space.

10334

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.

24 1929

County *Greene*

Registration District No. *318*

Township *Springfield* Primary Registration District No. *29A*

City *Springfield* (No. *Burgs Hospital*)

File No. *292*
Registered No. *292*
St. _____ Ward _____

2. FULL NAME *Frances Emery Jackson*

(a) Residence. No. *1626 E. Florida* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* | 4. COLOR OR RACE *white* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar. 27 1929*

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

17. I HEREBY CERTIFY That I attended deceased from *Mar. 26*, 19*29* to *Mar. 27*, 19*29* that I last saw h. *alive* on *Mar. 27*, 19*29*, and that death occurred, on the date stated above, at *2:10* p.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 26-1929*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	0	0	1	

Asphyxia pallida
161 D
158 (duration) yrs. mos. *2* da.

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

CONTRIBUTORY (SECONDARY) *malnutrition*
(duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) *Mo. Springfield*
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *✓*

10. NAME OF FATHER *Emery A. Jackson*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____
WAS THERE AN AUTOPSY? *no*

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

WHAT TEST CONFIRMED DIAGNOSIS *clinical*
(Signed) *Arthur D. Knabbe, M.D.*

12. MAIDEN NAME OF MOTHER *Blanche L. Burrow*

(Address) *450 1/2 E. Canal - 4-5, 1924*

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

*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.

14. INFORMANT *Emery A. Jackson*
(Address) *Springfield, Mo.*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Wesley Chapel cemetery* DATE OF BURIAL *3/28 1929*

15. FILED *4-5, 1929* *Lon Sharp* REGISTRAR

20. UNDERTAKER *J. W. Klingner* ADDRESS *424 E. Canal Springfield, Mo.*

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