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

Do not use this space.
10869 10919

File No. .....
Registered No. .....

1. PLACE OF DEATH
County Jackson — Registration District No. .....
Township Raw — Primary Registration District No. .....
City K.C. Mo (No. St. Joseph Hosp ..... St. ..... Ward)

2. FULL NAME Joseph E. Jackson

(a) Residence. No. 403 Olive 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. ..... 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)
M	W	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 1-1845

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
83	3	21 22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Engineer
(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) Wiss

PARENTS
10. NAME OF FATHER don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Eng
12. MAIDEN NAME OF MOTHER don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Eng

14. INFORMANT William Mandell
(Address) 3000 E 72 St

15. FILED 3/25 29 19 ..... By Clerk
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-22 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to March 22, 1929 that I last saw him alive on March 22, 1929, and that death occurred, on the date stated above, at 10 P.M. .....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
~~Primary~~ Angina Pectoris
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) Amputation Left Thigh for gangrene 2 for Diabetes Mellitus
(duration) ..... yrs. 2 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Eugene P. Hamilton, M. D
3-23, 1929 (Address) 607 Ralph K.C. 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	DATE OF BURIAL
Parkville Mo	3-24 1929
20. UNDERTAKER	**ADDRESS**
Harry Noland	Parkville

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.

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