

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

Do not use this space.

26 1929

22062

**1. PLACE OF DEATH**

County Marion Registration District No. 547  
Township Marion Primary Registration District No. 3029  
City Hannibal (No. 2511 Hope) St. 6 Ward

File No. 148  
Registered No. 148  
St. 6 Ward

**2. FULL NAME**

(a) Residence. No. 2511 Hope St. 6 Ward. (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 Colored  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Jackson  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 15, 1863  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
43      5      30

**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) Marion County, Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Willie McAfee  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Dora Knott  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)  
(STATE OR COUNTRY)

14. INFORMANT Mrs. J. Woodson  
(Address) Hannibal, Mo.

15. FILED 6/19, 1929 B. Houston Deputy REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-14-1929  
17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929 to June 14, 1929  
that I last saw her alive on June 14, 1929 and that death occurred, on the date stated above, at 11:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Carcinoma of stomach  
48 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 46 (duration) yrs. mos. ds.

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

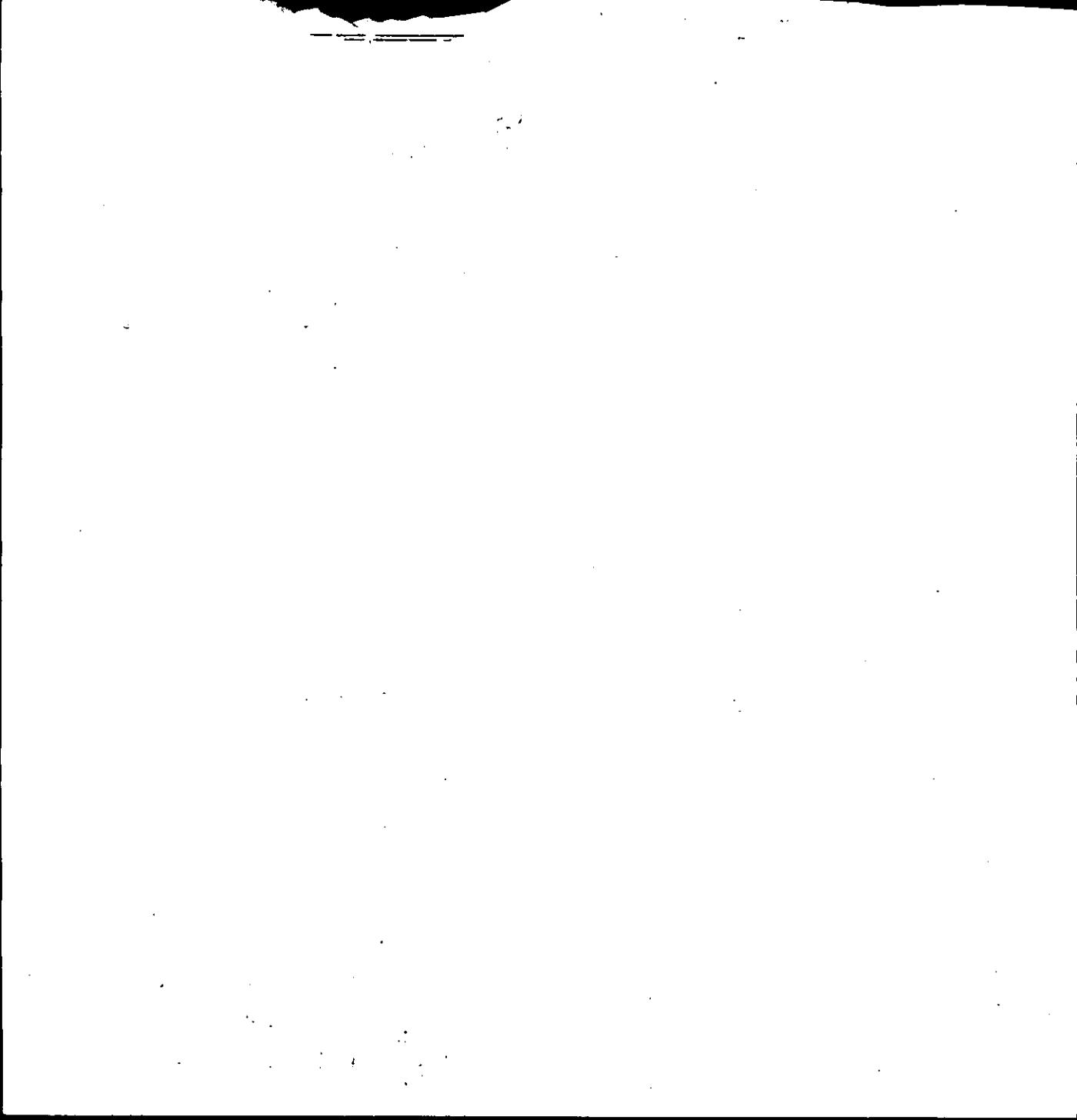
DID AN OPERATION PRECEDE DEATH? No DATE OF.....  
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) D. W. Fox M. D.  
June 7, 1929 (Address) 1216 Cedar

\*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 Quincy Ill.  
DATE OF BURIAL 6-17-1929

20. UNDERTAKER James D. Darnell  
ADDRESS Hannibal Mo.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Marion Registration District No. 347 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3029 Registered No. 148  
 City Hannibal (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Emma Jane 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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 15 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
65 5 7 29

**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) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_  
 12. MAIDEN NAME OF MOTHER \_\_\_\_\_  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

15. FILED 6/17 1929 B. Houston REGISTRAR  
Deputy

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6 - 14 1929

17. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 \_\_\_\_\_ (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**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL 1929 PRESCRIBED BY LAW

1929  
#22062