54
SEP 25 1929
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
County Lafayette — Registration District No. 460 — File No. 25085
Township ~~Davis~~ — Primary Registration District No. 4274 — Registered No. 59
City Higginsville (No. ..... St. ..... Ward)

2. FULL NAME Mrs Mattie Benedict 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 10 - 1854

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	4	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(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) Virginia

PARENTS
10. NAME OF FATHER Phillip P Gains
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Francis Corbin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Virginia

14. INFORMANT Mr Ed Gaines
(Address) Higginsville Mo

15. FILED 7/30, 1929 Bessie P Pitts
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 30, 1929

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 30, 1929 that I last saw her alive on July 30, 1929, and that death occurred, on the date stated above, at 7.45 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral regurgitation
92 P
77 P
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Rheumatic Fever
(duration) 30 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? No
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Usual Physical signs.
(Signed) J. Allen DO ~~M.D.~~
July 31, 1929 (Address) Higginsville 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: City Cemetery — DATE OF BURIAL: July 3/1929

20. UNDERTAKER: Hoffer & Wiemenshagen — ADDRESS: Higginsville Mo

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD