

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

Do not use this space.

APR 23 1930

7770

1. PLACE OF DEATH

County Buchanan
Township St. Joseph mo.
City St. Joseph mo. (No. 1576 - Sylvanias)

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 312
St. _____ Ward)

2. FULL NAME

Marion U. Jackson
(a) Residence. No. 15-16 - Sylvanias 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-14-1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>1</u>	<u>6</u>	<u>26</u>	<u>26</u>	<u>26</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child -
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Joseph mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Robert Jackson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Cameron mo.
12. MAIDEN NAME OF MOTHER Berta Leegay -
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Parksville mo.

14. INFORMANT Robert Jackson
(Address) 15-16 Sylvanias dr

15. FILED 11 1930 John G. W. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 Mar 30

17. I HEREBY CERTIFY, That I attended deceased from 10 Mar 30 to 10 Mar 30 that I last saw him alive on 9 Mar 30 and that death occurred, on the date stated above, at 9:5 am.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Gastroenteritis
1198
1068
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Recent
Menstruation (duration) yrs. 1 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? Clinical
(Signed) W. H. B., M. D.

(Address) 1908 Penna

*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 Cameron mo. DATE OF BURIAL Mar 12 1930

20. UNDERTAKER B. F. Graves ADDRESS 806-S-174

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.

RECORD

THIS IS A PERMANENT RECORD

