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.

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

Do not use this space.

24564

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo (No. City Hosp. #2 ..... St. ..... Ward)

File No. .....

Registered No. 6721

2. FULL NAME Edna Jackson

(a) Residence. No. 123 Elm st. St., 25 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	col	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt	23			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife 1758
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Muskoga
(STATE OR COUNTRY) Alka

PARENTS

10. NAME OF FATHER Mack Drake

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Richmond Virg

12. MAIDEN NAME OF MOTHER Mary Drake

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Vermham Texas

14. INFORMANT Silas Drake
(Address) 1530 So. 3rd st.

15. FILED JUL 12 1930 Max C. Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/9 1930

17. No Physician Attendance

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19..... and that death occurred, on the date stated above, at 7 20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Haemorrhage of Brain
Traumatic
Struck on head with Chair
..... (duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. W. Kerner ~~M. D.~~
7/11, 1930 (Address) Dep. Corner

*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
Father Dixon	7/12 1930
20. UNDERTAKER	ADDRESS
Ellis Funeral Home	2820 Stoddard st.