

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

Do not use this space.
26815

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City

Registration District No. 399
Primary Registration District No. 1007
(No. 5th Cherry in Auto)

File No. _____
Registered No. 3420
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 45 133 Washington St. Ward. 7
(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 1 - 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
38 . 11 15

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) White Cloud Kas.

10. NAME OF FATHER Shur Jackson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Charleston Mo.

12. MAIDEN NAME OF MOTHER Ida Anderson

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

14. INFORMANT. Mrs. Lucie Jackson
(Address) 4533 Washington

15. FILED 8/18 30 M. M. Conine
REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 16 1930 Saturday

17. 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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
suicide, fire arm
167

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) shot self through head
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Stanley M. Hull, M. D.
8/16 19 30 (Address) Deputy Coroner

*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 Mt. Washington DATE OF BURIAL 8-18 1930

20. UNDERTAKER Eglar Funeral Home ADDRESS 1800 Duwood

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.

