

007 31 1930

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

Do not use this space.

30621

File No. 87
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH
County Missouri Registration District No. 821
Township East Primary Registration District No. 6090
City _____ (No. _____) _____ St. _____ Ward _____

2. FULL NAME Reverna Jackson
(a) Residence. No. Mathews 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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 26 1912

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 5 20

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Miss

10. NAME OF FATHER Thomas Jackson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Miss

12. MAIDEN NAME OF MOTHER Ida Dean

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

14. INFORMANT Thomas Schlar
(Address) Mathews Mo

15. FILED 10/10/30 Walter E. Dues
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 to Sept 14 1930
that I last saw him alive on Sept 13 1930, and that death occurred, on the date stated above, at 11 o'clock PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 Typhus fever
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

10 (duration) yrs. mos. ds. 14

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? Microsc

(Signed) W. H. Myrtle, M. D.

Sp. 15, 1930 (Address) Rekaton 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 Sunset Addition DATE OF BURIAL 9/15 1930

20. UNDERTAKER L. S. Williams ADDRESS Rekaton Mo

PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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