

DEC 22 1930

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

Do not use this space.

36648

1. PLACE OF DEATH
County Lafayette Registration District No. 460
Township _____ Primary Registration District No. 21274
City Higginsville St. _____ Ward _____

2. FULL NAME Matthe Lee 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 2 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 9 1926

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
42 years 9 10

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

9. BIRTHPLACE (CITY OR TOWN) Higginsville
(STATE OR COUNTRY) Missouri, Lafayette

10. NAME OF FATHER Ely. Oliver

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Summerset
(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Sarah A. Oliver

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Frederick B.
(STATE OR COUNTRY) Maryland

14. INFORMANT J. F. Jackson
(Address) Higginsville Mo

15. FILED 11-11-30 Bessie P. Porter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from only
on Nov 9, 1930 to _____, 19____, 19____
that I last saw her alive on Nov 9, 19____, and that
death occurred, on the date stated above, at _____m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of breast
a long time (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Symptoms
(Signed) H. B. Mott, M. D.
Nov 10 1930 (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.

PLACE OF BURIAL, CREMATION, OR REMOVAL City Cemetery DATE OF BURIAL 11/11/1930
20. UNDERTAKER Hoepfner & Meierhagen ADDRESS H-ville. 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.

