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

Do not use this space.

37577

File No. 37577

Registered No. 10660

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

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

City St. Louis (No. 4236 Delmar St. ..... Ward)

2. FULL NAME Andrew Jackson

(a) Residence. No. 4236 Delmar St., 19 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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)
M.	W.	W.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 31-1850

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	80	2	9	

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

9. BIRTHPLACE (CITY OR TOWN) Frankford
(STATE OR COUNTRY) Ky.

PARENTS

10. NAME OF FATHER Nathan Jackson

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

12. MAIDEN NAME OF MOTHER Unknown Watson

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

14. INFORMANT Minnie Lynch
(Address) 4236 Delmar

15. FILED 10 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-9-1930

17. I HEREBY CERTIFY, That I attended deceased from April 10 —, 1930, to Nov 9 —, 1930 that I last saw him alive on 10-28-, 1930, and that death occurred, on the date stated above, at 8 a m m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Heart Lesion
Operation, removal of Leg for Diabetic Ulcer
(duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) ? yrs. mos. ds.

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18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? Yes. DATE OF Apr. 10-30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? No

(Signed) [signature], M. D.
11-9-1930 (Address) 607 N. Grand Bl.

*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
Kensett Ark	11/11 1930

20. UNDERTAKER	ADDRESS
Shaffer Und.	Sullivan 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.

WITH UNFADING INK—THIS IS A PERMANENT RECORD