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

Do not use this space.

39721

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No. 5248
City Kansas City (No. General Hospital # E St. Ward)

2. FULL NAME Owen Jackson
(a) Residence. No. 716 Campbell St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 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: Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: none
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unk 1900
7. AGE: Years 30 ? Months Days — If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Garage
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Okla

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Mrs. M. Reed
(Address) 920 Central St
15. FILED 12/31, 1930 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-25-30
17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner, 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:
Homicide - Knife
174
(duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (SECONDARY) 198
(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
19. WHAT TEST CONFIRMED DIAGNOSIS? autopsy
12/25/30 (Signed) [illegible], M. D.
(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: Blue Ridge — DATE OF BURIAL: Jan. 15 1931
20. UNDERTAKER: Adkins Bros — ADDRESS: 2000 E. 12th

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.