

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

Do not use this space.

9482

1. PLACE OF DEATH

County Greene Registration District No. 317
Township Wilson Brook Primary Registration District No. 5442
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME William Andrew 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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Caria Jackson</u>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 25 1865</u>			
7. AGE	YEARS <u>65</u>	MONTHS <u>10</u>	DAYS <u>16</u>
	If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

PARENTS	10. NAME OF FATHER <u>Andrew Jackson</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>
	12. MAIDEN NAME OF MOTHER <u>Emiline</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>

14. INFORMANT Oda Smith
(Address)

15. FILED 3-11 1931 W. W. Shover
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 9 1931
I HEREBY CERTIFY, That I attended deceased from Jan 10 1931 to Mar 9 1931
that I last saw him alive on March 9 1931 and that death occurred, on the date stated above, at 9:12 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Regurgitation - Dilated hypertrophy of heart. Broken embolus with profuse feet & legs (duration) but known yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Coronary (duration) 12 hrs yrs. mos. ds.

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? Empyical Exam
(Signed) C. B. Callahan M. D.
, 1931 (Address) 318 College St

*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 Brookline Cem DATE OF BURIAL Mar. 11 1931

20. UNDERTAKER J. W. Maple ADDRESS Clever Mo.

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.

APR 8 1931

