

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

Do not use this space.

34-170

**1. PLACE OF DEATH**

County Greene  
Township Springfield  
City Springfield

Registration District No. 318  
Primary Registration District No. 2001

File No. 727  
Registered No. 727  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 1611 E. Commercial 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX male 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 Daisy M. Jackson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 6 - 1872

7. AGE YEARS 59 MONTHS 3 DAYS 2 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carpenter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation 23

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

13. NAME Joseph Jackson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

15. MAIDEN NAME Lorraine Wallace

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) J. Jackson Mo. Springfield

18. BURIAL, CREMATION, OR REMOVAL PLACE Resurrection Chapel DATE 10-29-31

19. UNDERTAKER (ADDRESS) W. Kingman & Co. Springfield Mo.

20. FILED 10-29-31 Lon Sharp Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 8 1931

22. I HEREBY CERTIFY, That I attended deceased from Oct 1 1931, to Oct 8 1931. I last saw him alive on Oct 7 1931. Death is said to have occurred on the date stated above, at 3:15 a.m.

The principal cause of death and related causes of importance were as follows:

Pulmonary tuberculosis Date of onset 4 yrs  
DB  
Other contributory causes of importance \_\_\_\_\_

Name of operation Cholecystectomy Date of \_\_\_\_\_  
What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify Arthur W. Knapp, M. D.  
(Signed) \_\_\_\_\_  
(Address) 450 1/2 E. Comel

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.

NOV 24 1931

785