

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

Do not use this space.

4247

1. PLACE OF DEATH
 97 County Saline Registration District No. 796
 50 Township Primary Registration District No. 3038
 7 City Marshall, Mo. (No., St. Ward)
 2. FULL NAME J. D. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 15, 1928
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 2 12
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. child
 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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-27, 1933
 22. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1933 to Jan 27, 1933
 I last saw him alive on Jan 25, 1933 Death is said to have occurred on the date stated above, at 10:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia 1/25/33
197A

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marshall, Mo.
 13. NAME J. D. Jackson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hancock, Mo.
 15. MAIDEN NAME Grace House
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas
 17. INFORMANT J. D. Jackson (ADDRESS) Marshall, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Country Home DATE Jan 28, 1933
 19. UNDERTAKER (ADDRESS) G. G. Surrency Marshall, Mo.
 20. FILED 2-8- 1933 H. C. Putman Registrar.

Other contributory causes of importance:
 Name of operation Clinical 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
 (Signed) [Signature], M. D.
 (Address) Marshall, Mo.

COPIES OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1933

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Saline
Township
City Marshall (No. , St. Ward)

Registration District No. 796
Primary Registration District No. 3038

File No.
Registered No.

2. FULL NAME

(a) Residence, No. E. D. Jackson St. Ward.

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 2 -

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

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

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

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

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

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 19

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 27 19 33

22. I HEREBY CERTIFY, that I attended deceased from 19 to 19

I last saw h. alive on 19. Death is said to have occurred on the date stated above, at m.

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

Bronchitis - pneumonia Date of onset

Other contributory causes of importance:

Name of operation no Date of 107a
What test confirmed diagnosis? Was there an autopsy?

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? If so, specify

(Signed) M. D.

(Address)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. CHAS. de. in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S- 4247