

Bureau of Vital Statistics  
CERTIFICATE OF DEATH

County Fremont Registration District No. 651 10558  
 Township Cooter Primary Registration District No. 5873 Registered No. 10558  
 Inc. Town Hammond City Hammond (No. 10558) St. 1 Ward 1

2 FULL NAME Jobe Jackson

(a) Residence. No. Hammond St., 1 Ward. 1  
 (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 M 4 COLOR or RACE Ed 5 Single Married, Widowed, or Divorced (write the word)

8a If married, widowed, or divorced  
 HUSBAND of  
 (or) WIFE of

6 DATE OF BIRTH \_\_\_\_\_ 1  
 Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

7 AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
 If LESS than 1 day, ..... hrs. or ..... min.

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

9 BIRTHPLACE (city or town) Missouri  
 (State or country)

10 NAME OF FATHER \_\_\_\_\_

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
 (State or country)

12 MAIDEN NAME OF MOTHER Matha Lawton  
 13 BIRTHPLACE OF MOTHER (city or town) Missouri  
 (State or country)

14 Informant James Scott  
 (Address) Hammond St. No. 10558

15 Filed \_\_\_\_\_ 19 \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 - 11 - 1935  
 Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

17 I HEREBY CERTIFY, That I attended deceased from  
non attended, 19 \_\_\_\_\_

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_

and that death occurred, on the date stated above, at 2:00 AM  
 The CAUSE OF DEATH was as follows:

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. (See reverse side for additional space.)

Pneumonia 109th  
120th

(duration) yrs. mos. 6 ds.

CONTRIBUTORY Enteritis  
 (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted  
 if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_

What operation performed? none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B. G. Roberts M. D.

3-15-1935 (Address) Blytheville

19. PLACE OF BURIAL, CREMATION, or REMOVAL Kanada Switch  
 DATE OF BURIAL 3/19/35

20 UNDERTAKER Leahy & Cobb ADDRESS Blytheville

Burial or Permit issued by \_\_\_\_\_ Date of issue \_\_\_\_\_  
 Transit

N. B.—WRITE PLAINLY, WITH "UNFADING INK"—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by  
U. S. Census and American Public Health Association)

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mins, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home,* and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

**STATEMENT OF CAUSE OF DEATH.**—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia," (merely symptomatic), "Atrophy," "Collapse,"

"Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association).

Note.—Certificates may be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

**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 Platte Registration District No. 656  
Township 6 water Primary Registration District No. 5873  
City (No. ) St. Ward

File No. 16  
Registered No. 16

**2. FULL NAME**

Fake Jackson  
(a) Residence, No. 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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

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

22. I HEREBY CERTIFY, That I attended deceased from None attended, 19

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11/19/1891

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 36 11 19 11 11

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

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

Date of onset

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

Pharyngitis

10. Date deceased last worked at this occupation (month and year)

Other contributory causes of importance:

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

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13. NAME

Essential

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

Name of operation Tracheotomy Date of.....

15. MAIDEN NAME Martha Harrison

What test confirmed diagnosis? Tracheotomy Was there an autopsy? Yes

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

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

17. INFORMANT (ADDRESS) James Scott

Where did injury occur? ruh (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

Specify whether injury occurred in industry, in home, or in public place.

19. UNDERTAKER (ADDRESS) Healy & Cobb

Manner of injury.....

20. FILED May 9, 1933 A. Harrison Registrar

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) B. E. Roberts, M. D.

(Address) Boylstonville, 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

10558