

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

Do not use this space.

29782

1. PLACE OF DEATH

County Jackson Registration District No. 585 File No. _____
 Township Boonville Primary Registration District No. General Hospital Registered No. 3705
 City Boonville, Mo. (No. _____) (St. _____) (Ward _____)

2. FULL NAME

(a) Residence, No. 813 E. 16th 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 <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Gertrude Jackson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-4-1887</u>		
7. AGE YEARS <u>46</u>	MONTHS	DAYS <u>13</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Unemployed</u>		
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) <u>Mo.</u>		
13. NAME <u>Wm Jackson</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
15. MAIDEN NAME <u>Myra (C) Jackson</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
17. INFORMANT (ADDRESS) <u>Record Clerk</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE <u>Highland Cem. K.C. Mo. 9-20-33</u>		
19. UNDERTAKER (ADDRESS) <u>Flynn + Greenstreet K.C. Mo.</u>		
20. FILED <u>9-19-1933</u> <u>M. M. Crowe</u> Registrar.		

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-17-1933

22. I HEREBY CERTIFY, That I attended deceased from 8-10, 1933 to 9-17, 1933
 I last saw him alive on 9-17, 1933 Death is said to have occurred on the date stated above, at 12:10 P.M.
 The principal cause of death and related causes of importance were as follows:
Had a diagnosed pulmonary tuberculosis (ulcers - cavity formation) Date of onset 3 2 34
 Other contributory causes of importance: Tapnia 5 6 9 3

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

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) R. O. Brown M. D.
 (Address) Central Hosp. #2

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.

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