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 25 1934

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

Do not use this space.

11461

1. PLACE OF DEATH

County St. Louis — Registration District No. 1123 — File No.

Township — Primary Registration District No. 624 B — Registered No. 91

City Jefferson Barracks, Mo. (No. Veterans' Administration Facility, St. Ward)

2. FULL NAME Percy JACKSON

(a) Residence, No. Caruthersville, Mo. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	COLORED	Married (Separated)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 19, 1894

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	39	7	5	

OCCUPATION

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

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

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

11. Total time (years) spent in this occupation Unavailable

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid Missouri

FATHER

13. NAME Thomas Jackson

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

MOTHER

15. MAIDEN NAME Mary LaForge

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

17. INFORMANT (ADDRESS) E.T. Gallagher, M.D., Act. Clin. Dir., Vets. Adm. Fac., Jeff. Bks., Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Nat. Cem. DATE Mch 27 1934

19. UNDERTAKER (ADDRESS) Idas L. Gales 4107 Finney ave

20. FILED 3/26 1934 B. H. Tate M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

3

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24, 1934

22. I HEREBY CERTIFY, That I attended deceased from February 9, 1933, to March 24, 1934

I last saw him alive on March 24, 1934. Death is said to have occurred on the date stated above, at 6:17 A.M.

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

	Date of onset
Cerebral Hemorrhage	Unkn.
190	
488	
824	
Other contributory causes of importance: Spastic Quadriplegia, incident to Cerebral Hemorrhage-	Unkn.
Gangrene of left leg, -right foot-	
Oper.-Amputation of Gangrenous parts, lft. leg, rt. leg.	Mar. 2, 33 June 7 & Aug. 11/33

Name of operation — Date of

What test confirmed diagnosis? Clinical and operation. 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?

If so, specify

(Signed) W. C. GIBSON, M.D., Manager

(Address) Vets. Adm. Fac., Jeff. Bks., Mo.

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: St. Louis — Registration District No.: 1123
Township: — Primary Registration District No.: 624813
City: Jefferson Barracks — No. ..... St. ..... Ward)

File No. .....
Registered No. 91

2. FULL NAME: Percy Jackson
(a) Residence, No. ..... Carutherwillle Ward. Mo.
(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: Male
4. COLOR OR RACE: Col.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Mar.

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.

OCCUPATION
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)

FATHER
13. NAME .....
14. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME .....
16. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

17. INFORMANT ..... (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ..... 19....

19. UNDERTAKER: Chas J. Gates (ADDRESS) 4107 Finnie Ave

20. FILED 3-26, 1934 B. H. Tate M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 24, 1934

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:

	Date of onset
Cerebral Hemorrhage	

Other contributory causes of importance:

Gangrene of left Foot
Name of operation: Result of Frostbite Date of .....
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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC...

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED.

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