

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

Do not use this space.

170
16789
File No. _____
Registered No. _____

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township 2nd mo. Primary Registration District No. _____
City St. Louis (No. General Hospital #2 St. 3rd Ward)

2. FULL NAME

Henrietta Jackson
(a) Residence, No. 1429 Indep. Ave. Ward. _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

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

7. AGE YEARS 38 MONTHS _____ DAYS _____ IF LESS than 1 day, _____ hrs. _____ min.

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

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) Little Rock, Ark.

13. NAME Henry Jackson

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

15. MAIDEN NAME Prudella White

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

17. INFORMANT (ADDRESS) Record Clerk General Hosp #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Rest Lawn DATE 5-15 1934

19. UNDERTAKER (ADDRESS) H.C. Embury & Co. 445 State Ave.

20. FILED May 15, 1934 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-13 1934

22. I HEREBY CERTIFY, That I attended deceased from 5-7 1934, to 5-13 1934. I last saw him alive on 5-13 1934. Death is said to have occurred on the date stated above, at 2:40 P.M.. The principal cause of death and related causes of importance were as follows:
Cerebral Apoplexy (Specify)
Meningeal
Other contributory causes of importance: 34

Name of operation _____ Date of _____
What test confirmed diagnosis Clinical 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. _____

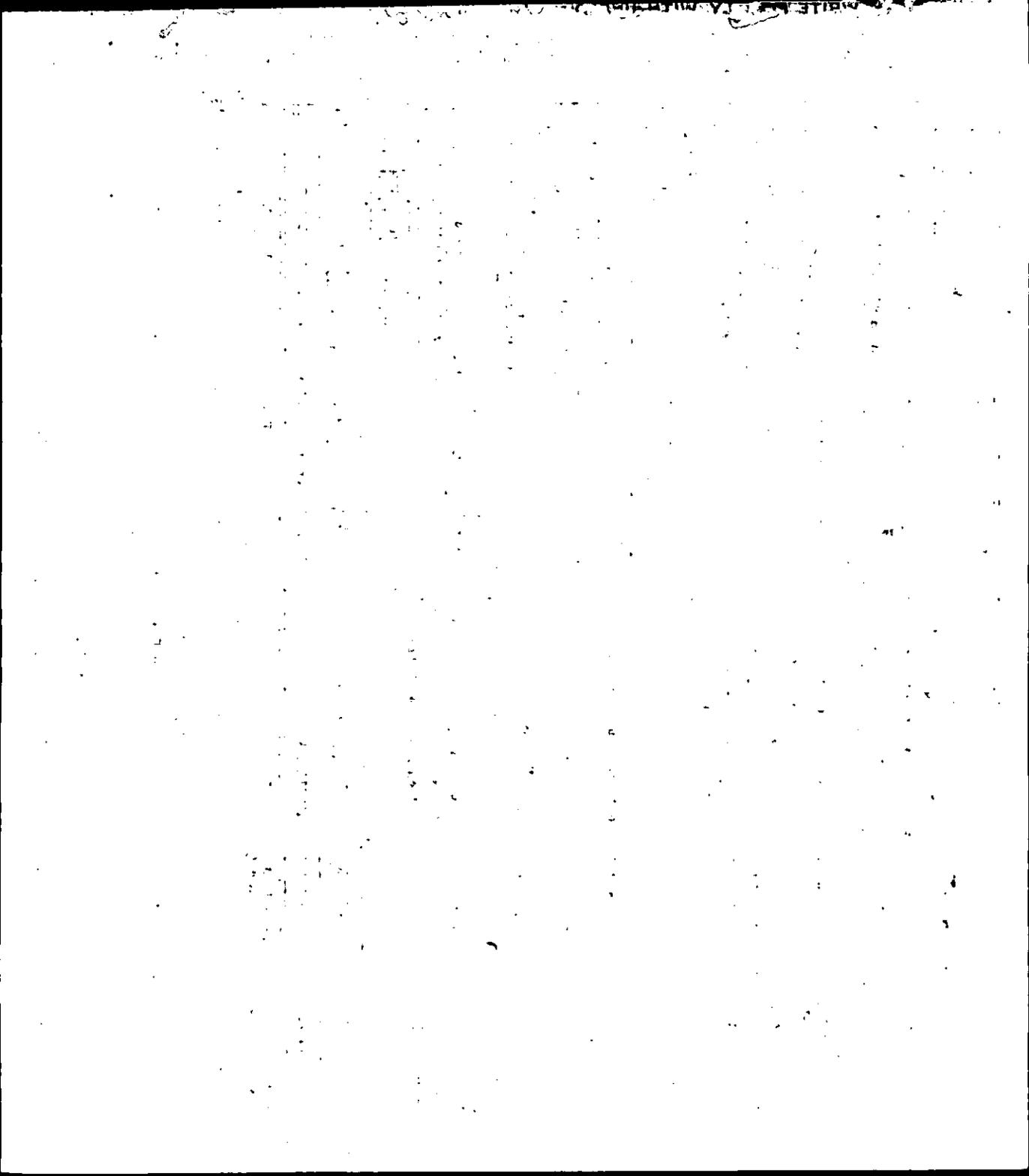
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) S. O. Brown M. D.
(Address) General Hosp #2

JUN 19 1934

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.



#2 KC

DEPARTMENT OF COMMERCE

E. T. McGaugh, M. D.,

BUREAU OF THE CENSUS

Special Agent,

Jefferson City, Mo.

16789

2158

Jackson

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Hennetta Jackson

Who died at Sen Hoop #2 on May 13 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: _____ Years _____ Months _____ Days _____

Sex F Color or race B Single, married, widowed or divorced: X

Date of birth _____ Age: abt 38 Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Cerebral apoplexy Specified Syphilitic Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Menigeum

Other contributory causes of importance Typhoid

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? (over)

If so, specify _____

Name of physician D. C. Turner

Address of physician Sen Hoop #2

Signature of Registrar M. M. Brown Date filed 5/15/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours, E. T. McGaugh

Reg. Dist. No. _____ Primary Reg. Dist. No. _____
State Registrar

Special Agent.

no more information available

S-16789