

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

Do not use this space.

2203

1. PLACE OF DEATH FEB 20 1936

County Miss Registration District No. 369
Township Ohio Primary Registration District No. 5765
City Wright mo (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME Isaac 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. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) D.K.
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 45

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Shaveroppper
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Farm
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) Dont know miss.

MOTHER 13. NAME Isaac Jackson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K. miss

15. MAIDEN NAME Dont know

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

17. INFORMANT (ADDRESS) Sara Jackson

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE 2/2/36

19. UNDERTAKER (ADDRESS) Smith Co.

20. FILED 1/20 1936 At Marshall Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/20 1936

22. I HEREBY CERTIFY, That I attended deceased from Sept 29 1936, to 1/20 1936.
I last saw him alive on 1/6 1936 Death is said to have occurred on the date stated above, at 4:00 p.m.
The principal cause of death and related causes of importance were as follows:

Enteritis
(Cause not known)
Date of onset 9/29/36
Other contributory causes of importance Secondary Bacteremia

Name of operating hospital _____ Date of _____
What test confirmed diagnosis? Cl. Sympt 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) C. Chas. Salvey M. D.
(Address) Charleston 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.

by Mrs. W. Marshall

