

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

Do not use this space.

21828

1. PLACE OF DEATH

County North
Township Franklin
City Springfield (No. 1545)

Registration District No. 903
Primary Registration District No. 1545

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Alice Elizabeth Jackson

(a) Residence, No. _____ St. _____ 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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF L. Jackson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-3-1866
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
68 27

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) Springfield, Mo.

13. NAME Geo. Gray

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

15. MAIDEN NAME E. Liza Claypool

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE Franklin City DATE 5-15-1936

19. UNDERTAKER (ADDRESS) Franklin City

20. FILED 7-9 19 36 Franklin City, Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-20-1936

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. alive on 5-14, 1936 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:

Cancer of uterus and peritonitis
Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ 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) Fred M. Miller, M. D.

(Address) Franklin City, Mo.

Registrar

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.

