

JUL 2 1936

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

Do not use this space.

22945

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Knox Primary Registration District No. 1002
City Russell City (No. 514 1/2 Main)

File No. 2077
Registered No. 2077
St. _____ Ward _____

2. FULL NAME

Jacob M. Poston
(a) Residence, No. 514 1/2 Main 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. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
apt. 57. X X

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer
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) Unknown

MOTHER FATHER
13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Unknown

18. BURIAL, CREMATION OR REMOVAL PLACE Waller Cemetery DATE 6-10-36

19. UNDERTAKER (ADDRESS) H. J. Jernigan & Sons, Russell City, Mo.

20. FILED 6/15/36 19 36 M. M. Corro Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/9/36 19 _____
22. I HEREBY CERTIFY that I attended deceased from _____, 19 _____
I last saw him alive _____, 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:
Mental disease Date of onset _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis _____ Was there any 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) [Signature], M. D.
(Address) [Signature]

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.

