

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

Do not use this space.

**1. PLACE OF DEATH** *JUN 1 1937*  
 County *Jackson* Registration District No. *399*  
 Township *1st Mo.* Primary Registration District No. *1002* File No. *18916*  
 City *General Hosp. #21* (No. *3100*) Registered No. *3100* St. *3rd* (Ward)

**2. FULL NAME** *Lula Jackson*  
 (a) Residence, No. *2427 Brooklyn* 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** *Female* **4. COLOR OR RACE** *Colored* **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** *Single*  
 (write the word)

**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)** *1-7-1878*  
**7. AGE** YEARS *59* MONTHS *3* DAYS *24* If LESS than 1 day, hrs. or min.

**8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.** *None*  
**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)** *Mo.*

**FATHER**  
**13. NAME** *John Williams*  
**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** *Versailles Mo.*

**MOTHER**  
**15. MAIDEN NAME** *Josephine*  
**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** *Versailles Mo.*

**17. INFORMANT (ADDRESS)** *Record Clerk*

**18. BURIAL, CREMATION, OR REMOVAL**  
 PLACE *Highland* DATE *5/6* 19*37*

**19. UNDERTAKER (ADDRESS)** *Hatkins Bros 1729 1/2 Mo.*

**20. FILED** *May 6, 1937* *M. M. Crowe, esq.* Registrar.

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** *5-1-1937*

**22. I HEREBY CERTIFY, That I attended deceased from** *4-1* No. *37*, to *5-1* 19*37*  
 I last saw her alive on *5-1-37*, 19*37* Death is said to have occurred on the date stated above, at *4:25* A. M.  
 The principal cause of death and related causes of importance were as follows:  
 Date of onset

*Cerebral Athero-sclerosis (820)*  
*Encephalomalacia*

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *Yes*

**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) *J. C. Burner* M. D.  
 (Address) *General Hosp. #2*

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.

