

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

34678
Do not use this space.

1. PLACE OF DEATH *NEW NOV 21 1938*

(a) County *Jackson* Registration District No. *395*

(b) Township *Glenn* Primary Registration District No. *1002*

(c) City *R. C. Mo.* (d) Street No. *General Hospital #2* Registered No. *4014*

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *David Jackson*

(a) Residence, No. *1208 W. 29th St.* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*

4. COLOR OR RACE *Coloured*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Unknown*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 1st 1893*

7. AGE YEARS <i>45</i>	MONTHS <i>3</i>	DAYS <i>14</i>	IF LESS than 1 day,hra. ormin.
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8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. *Home Man*

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. 6*

FATHER

13. NAME *Geo Jackson* 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown* 9

MOTHER

15. MAIDEN NAME *Unknown*

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

17. INFORMANT (ADDRESS) *Record Clerk General Hospital #2*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Trinidad* DATE *Oct 14 1938*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *West Appleton Jones 1905 Vine St.*

20. FILE NO. *Dec 14 1938 M. M. Crowe* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-12 1938*

22. I HEREBY CERTIFY, That I attended deceased from *9-29 1938* to *10-12 1938*

I last saw him alive on *10-12 1938* Death is said to have occurred on the date stated above, at *5:05 a.m.*

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage. 82nd

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) *A. Dupuis*, M. D.

(Address) *General Hospital #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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed

E W West

Licensed Embalmer No.

2710

P. O. Address

R E M O

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.