REC'D MAR 17 1939

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

Do not use this space. 6663

1. PLACE OF DEATH
(a) County Holt
(b) Township Holt
(c) City Forest City
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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.

Registration District No. 370
Primary Registration District No. 4216
Registered No. 2

2. PRINT FULL NAME ANNA MARIA JACKSON
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John F Jackson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Dec 6 1855

7. AGE: Years 84 Months 2 Days 2 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: housewife
9. Industry or business in which work was done, as 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): Enon ohio

FATHER
13. NAME: John Wallace
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ohio

MOTHER
15. MAIDEN NAME: unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ohio

17. INFORMANT (ADDRESS): Cora Haddon

18. BURIAL, CREMATION, OR REMOVAL
PLACE Forest City DATE Feb 2 1939

19. FUNERAL DIRECTOR (ADDRESS): J Fred Jackson, Savannah Mo

20. FILED Feb 2 1939 F E Bullock Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 1-1939 19

22. I HEREBY CERTIFY, That I attended deceased from 25 years, 19..., to January 29-1939, 19..., I last saw h... alive on January 29-1939, 19..., Death is said to have occurred on the date stated above, at 1 A. m.
The principal cause of death and related causes of importance were as follows:

General paralysis of the insane of five years duration — Date of onset 87

Other contributory causes of importance:
Arterio sclerosis

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? No
If so, specify .....
(Signed) F E Bullock, M. D.
(Address) Forest City Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

8'8'

RECEIVED
District Health Officer No. 11,
District File Number 39-70
Date Filed MAR 9 1939

STATEMENT BY LICENSED EMBALMER

I, J. Fred Terhune, Licensed Embalmer No. 1279

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed J. Fred Terhune

Licensed Embalmer No. 1279

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

6663
Do not use this space.

1. PLACE OF DEATH
(a) County Hickory Registration District No. 370
(b) Township Primary Registration District No. 4216 Registered No.
(c) City Forest City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Anna Maria Jackson
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
84	2	2	

OCCUPATION
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.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 1 , 1939

22. I HEREBY CERTIFY, That I attended deceased from 19, to 19
I last saw h alive on 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:

General paralysis of the insane of five years duration
Senile paresis 8 3/-

Other contributory causes of importance:
Arterio Sclerosis

Date of onset

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) F. E. Bullock, M. D.
(Address) Forest City Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.