

REC'D MAY 11 1939

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

14869
Do not use this space.

1. PLACE OF DEATH

(a) County GREENERegistration District No. 318

(b) Township

Primary Registration District No. 2001Registered No. 301(c) City SPRINGFIELD(d) Street No. 921 Adams St.

(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

(a) Residence, No. 921 Adams St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Oscar Jones6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 4, 18767. AGE YEARS 62 MONTHS 10 DAYS 3 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. In Home 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.FATHER 13. NAME Frank Jackson14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.MOTHER 15. MAIDEN NAME Jane Sheffield16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.17. INFORMANT Oscar Jones (ADDRESS) 921 Adams18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis DATE April 10, 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Higgins20. FILED April 1939 Phar. A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 7, 193922. I HEREBY CERTIFY, That I attended deceased from Sept 1938 to Mar 25, 1939I last saw her alive on Mar 25, 1939 Death is saidto have occurred on the date stated above, at 5 P. m.

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

Pulmonary TB Date of onsetat least 2 to 3 years

Other contributory causes of importance:

Mitral Regurg

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. S. O'Leary, M. D.(Address) Springfield

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..... *Warren D. Hoblett*

Licensed Embalmer No. *4005*

P. O. Address *Springfield*

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.

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