

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

21118  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 3 Registration District No. 399  
(b) Township 1st Primary Registration District No. 1002  
(c) City St. Louis (d) Street No. 508 Walnut 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. 250 Arthur E. Jackson St.   
1604 Fremont (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lena D. Jackson  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 9-1888  
7. AGE YEARS 50 MONTHS 1 DAYS 0 IF LESS than 1 day, .....hrs. or .....min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Union Work  
9. Industry or business in which work was done, as saw mill, bank, etc. prop  
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 Nathan Jackson

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

MOTHER 15. MAIDEN NAME Marion Drumright

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

17. INFORMANT (ADDRESS) Mrs. Lena D. Jackson  
1604 Fremont

18. BURIAL, CREMATION, OR REMOVAL PLACE Springfield Mo DATE June 11, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robert Henderson  
St. Louis

20. FILE NO. June 11, 1939 M. M. Crose Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1939  
22. I HEREBY CERTIFY, that I attended deceased from ..... 19.....  
I last saw him on ..... 19..... Death is said to have been on the date stated above, at 3:15 p.m.  
The principal cause of death and related causes of importance were as follows:  
Date of onset

Chronic diffuse myocardial fibrosis  
Acute pulmonary congestion  
Other contributory causes of importance: 93c

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? If so, specify .....  
(Signed) Arthur E. Jackson M. D.  
(Address) Springfield, Mo

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**