

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

31904
Do not use this space.

1. PLACE OF DEATH ^{REC'D OCT 12 1939}

(a) County Buchanan 3 Registration District No. 3

(b) Township 1 Primary Registration District No. 1

(c) City St. Joseph (d) Street No. St. Hospital # 2 Registered No. 950

(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 James Jackson

(a) Residence, No. 1119 Highland St. Kennett Mo.
(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 male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 23, 1884

7. AGE YEARS 55 MONTHS 0 DAYS 11 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. com. laborer

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) Miss. 1

FATHER 13. NAME Wiley Jackson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss. 5

MOTHER 15. MAIDEN NAME Julia Grear

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Northline 2

17. INFORMANT (ADDRESS) Mrs. Jas. Jackson, 1119 Highland

18. BURIAL, CREMATION, OR REMOVAL PLACE Kennett College of St. Joseph DATE Sept 6 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Summer Thriftway, Kennett, Mo.

20. FILED Sept 14, 1939 W. J. Mottelburg
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 4 1939

22. I HEREBY CERTIFY, That I attended deceased from July 17, 1939, to Sept. 4, 1939

I last saw him alive on July 17, 1939. Death is said to have occurred on the date stated above, at 8:45 P. M.

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

Gen. paralysis of the insane meningo-encephalitis - syphilitic chronic

Date of onset no info

Other contributory causes of importance: 83

Name of operation none Date of no

What test confirmed diagnosis? Smear Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Planner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

(Signed) T. J. O'Dell, M. D.
(Address) St. Joseph

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.

1157

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 E.T. Whitaker

Registered Apprentice No. None, working under my personal supervision.

Signed W.C. Summer

Licensed Embalmer No. 2159

P. O. Address Irksville

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township St Joseph Primary Registration District No. 1001 Registered No. 950
(c) City St Joseph (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 James Jackson

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS 55 MONTHS 0 DAYS 11 IF LESS than 1 day, _____ hrs. or _____ min.

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 _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) Northline (STATE OR COUNTRY) State (unk)

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 11/20 1939 W. J. Northline Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19 _____

22. I HEREBY CERTIFY, That I attended deceased from _____ 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:

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) _____, M. D.

(Address) _____

Every item of information should be carefully checked for accuracy. Physicians, registrars shall not receive a fee for certificates until they are completed as prescribed by law. Exact statement of occupation is very important.

SUPPLEMENTARY

S-31904