

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

**32611**  
Do not use this space.

**OCT 20 1939**

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 400

(b) Township Prairie Primary Registration District No. 5553B Registered No. 168

(c) City Jackson (d) Street No. Jackson County Home for the Aged

(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. E. BLACK (full name unabbreviated)

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX mal 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-17-1858

7. AGE YEARS 81 MONTHS 4 DAYS 0 If LESS than 1 day, .....hrs. or .....min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 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) Ind.

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Ernest Jackson (ADDRESS) 2025 Home

18. BURIAL, CREMATION, OR REMOVAL (PLACE) K. E. Danta Co. DATE Aug 18, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) K. E. Danta Co.

20. FILED 9/8/39 1939 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-1, 1939, to 8-17, 1939

I last saw him alive on 8/16, 1939 Death is said to have occurred on the date stated above, at 5:12 m.

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

Date of onset 162

Other contributory causes of importance:

Name of operation clinical Date of no

What test confirmed diagnosis clinical 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 \_\_\_\_\_, 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) J. K. Green, M. D.  
(Address) in dependence

**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 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.

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

32611

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 400  
 (b) Township Prairie Primary Registration District No. 5353  
 (c) 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 7 yrs. 0 mos. 0 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 168

2. PRINT FULL NAME

Ammon E. Black

(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<br><u>m</u>  | 4. COLOR OR RACE<br><u>w</u>   | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>8</u> (Write the word) |   |  |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF              |  |   |   |  |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)                                   |  |   |   |  |
| 7. AGE  | YEARS<br><u>81</u>   | MONTHS<br><u>4</u>  | DAYS<br><u>0</u>                                | If LESS than 1 day, _____ hrs. or _____ min. |
| 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<br>PLACE _____ DATE _____, 19__         |  |   |   |  |
| 19. FUNERAL DIRECTOR (ADDRESS)  |  |   |   |  |
| 20. FILED <u>11-8-</u> 19 <u>39</u> <u>Saul H. Carne</u> Local Registrar. |  |   |   |  |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 17, 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:

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) J. H. Greene, M. D.  
 (Address) Independence

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CROSS OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

