DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 13 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

✓ State File No. 39416

Registration District No. 218 — Primary Registration District No. 3015 — Registrar's No. 121

1. PLACE OF DEATH:

(a) County: Cooper
(b) City or town: Boonville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: mo (b) County: Saline
(c) City or town: marshall (If outside city or town limits, write "RURAL")
(d) Street No. 371 n marion (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Palmer Jackson 150
3. (b) If veteran, name war: ____ 3. (c) Social Security No. ____

4. Sex: M | 5. Color or race: Black | 6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: ____ 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: July (Month) 19th (Day) 1901 (Year)

8. AGE: Years 38 | Months 3 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace: Saline Co. (City, town, or county) mo (State or foreign country) 0
10. Usual occupation: Hotel operator 0
11. Industry or business: 0

FATHER
12. Name: Palmer Jackson
13. Birthplace: Bethel (City, town, or county) mo (State or foreign country)

MOTHER
14. Maiden name: Laura Jones
15. Birthplace: Bethel (City, town, or county) mo (State or foreign country)

16. (a) Informant's own signature: Laura Jackson
(b) Address: marshall mo

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof 11-17-1939 (Month) (Day) (Year)
(c) Place: burial or cremation: marshall mo

18. (a) Signature of funeral director: Harry Hershberger
(b) Address: marshall mo

19. (a) 11-20 (Date received local registrar) (b) D. C. Hooper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month nov day 15-th year 1939 hour 11 minute 40 A. M.

21. I hereby certify that I attended the deceased from 11-1-39, to 11-15, 1939; that I last saw him alive on 11-11-39; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Fracture, right femur ✓	
Due to	
Due to	
Other conditions: Osteomyelitis (Include pregnancy within 3 months of death)	
Major findings: Of operations: Osteomyelitis, lower fragment.	PHYSICIAN — Underline the cause to which death should be charged statistically
Of autopsy	

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): accident, auto
(b) Date of occurrence: 11-1-39
(c) Where did injury occur? near Boonville, Cooper Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? While traveling on Highway (Specify type of place)
While at work? No (e) Means of injury: Car wreck

23. Signature: W. H. Carl, M.D. (M. D. or other)
Address: Boonville, Mo Date signed 11-15-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12/7/39

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed Fred Wilkerson

Licensed Embalmer No. 2478

P. O. Address Clinton Mo

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.

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

39416
Do not use this space.

1. PLACE OF DEATH
(a) County Cooper — Registration District No. 218
(b) Township Boonville — Primary Registration District No. 3015 — Registered No. 121
(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 ..... yrs. ..... mos. ..... ds. (f) How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. PRINT FULL NAME Palmer 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	B	S

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.
	38	3	26	

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.

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 15, 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
Fractured R femur	
2° to fall	
Other contributory causes of importance:	
Osteomyelitis	
Osteomyelitis bones leg	
Pneumonia.	

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? Accident Date of injury 11-1, 1939
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 Auto collision
Nature of injury Auto accident

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) W. E. Stone, M. D.
(Address) Boonville Mo

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.

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