DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 18 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40931

Registration District No. 744 Primary Registration District No. 4479

Registrar's No. 53

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.

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Slater
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Saline
(c) City or town: Slater
(If outside city or town limits, write "RURAL")
(d) Street No. ____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

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

4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: ____
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased: Feb. (Month) 25th (Day) 1857 (Year)

8. AGE: Years 82 Months 8 Days 18 If less than one day ____ hr. ____ min.

9. Birthplace: Indiana (City, town, or county) (State or foreign country)
10. Usual occupation: farmer
11. Industry or business: ____
FATHER
12. Name: Henry Jackson,
13. Birthplace: ____ (City, town, or county) England (State or foreign country)
MOTHER
14. Maiden name: Martha don't know
15. Birthplace: don't know (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: Mrs. Nell Blackmore
(b) Address: Slater, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 11/15/'39 (Month) (Day) (Year)
(c) Place: burial or cremation: Slater, Mo.
18. (a) Signature of funeral director: Hill Brothers
(b) Address: Slater, Mo.
19. (a) 11 15 (Date received local registrar) (b) W M Little (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 13th year 1939 hour 2 minute 30p M.

21. I hereby certify that I attended the deceased from Oct-30-1939 to Nov-13-1939 that I last saw him alive on Nov-13-1939 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage.
Due to: Arterio-Sclerosis
Due to: ____
Other conditions (Include pregnancy within 3 months of death): ____

Duration

Major findings:
Of operations: ____
Of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): ____
(b) Date of occurrence: ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury: ____

23. Signature: M C Dougherty (M. D. or other)
Address: Slater, Mo. Date signed 10/15/39

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 1/18/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by [redacted]

Edgar Moore, Registered Apprentice No. 230

working under my personal supervision.

Signed A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Slater, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.