

MAY 13 1940

Registration District No. **620-**

Primary Registration District No. **5827 3031**

Registrar's No. **41**

1. PLACE OF DEATH:

(a) County **nodaway**
 (b) City or town **Maryville**
 (If outside city or town limits write "RURAL" and name of township)
 (c) Name of hospital or institution: **None**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **59 years**
 years, months or days

3. (a) PRINT FULL NAME **Elizah Franklin Jackson**
 3. (c) Social Security No. _____
 8. (b) If veteran, name war No. _____

4. Sex **male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife **Jennie Potts Jackson** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Feb 13 1955**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	85	85	2	0
				hr. min.

9. Birthplace **Hampstead Maryland**
 (City, town, or county) (State or foreign country)

10. Usual occupation **farming**

11. Industry or business _____
 MOTHER FATHER { 12. Name **Benjamin Jackson**
 13. Birthplace **Maryland**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Salviana Cox**
 15. Birthplace **Maryland**
 (City, town, or county) (State or foreign country)

16. (a) Informant **J. B. Jackson**
 (b) Address **Barnard MO**

17. (a) **Burial** (b) Date thereof **4-15-1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **San tenary Cemetery**

18. (a) Signature of funeral director **Campbell Funeral Home**
 (b) Address **557 South Main Maryville Mo**

19. (a) **4-15-40** (b) **Mamie E. Clark**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Nodaway**
 (c) City or town **Maryville**
 (If outside city or town limits write "RURAL")
 (d) Street No. **124 1/2 west 3rd St.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4/13** day _____
 year **1940** hour **7:57** minute **0** M.

21. I hereby certify that I attended the deceased from **4/11**
 _____, 19 **40** to **4/13**, 19 **40**
 that I last saw him alive on **4/13**, 19 **40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic interstitial pneumonia**
nephritis
 Due to **prostatitis**
suppurativa
 Due to _____

Other conditions (include pregnancy within 3 months of death) **151**

Major findings: Of operations _____
 Of autopsy **no**

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature **G. E. Gosens** (M. D. or other) _____
 Address **Maryville** Date signed **4/15/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

[Handwritten notes and scribbles, including "The" and "1911" at the top, and various illegible markings below.]

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 the above constitutes grounds for revocation of license.)

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