

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 21

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 28 yrs. (Specify whether
years, months or days) _____

3. (a) PRINT FULL NAME Henry Jackson

3. (b) If veteran, name war _____ 3. (c) Social Security No. 492-03-981

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Effie Jackson 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased May 4 1887
(Month) (Day) (Year)

8. AGE: Years 58 Months 0 Days 1 If less than one day hr. _____ min. _____

9. Birthplace Milldale, Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Mill wale

11. Industry or business _____

12. Name Wm H. Jackson

13. Birthplace Ill. (City, town, or county) (State or foreign country)

14. Maiden name Anderson

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Effie Jackson

(b) Address Sikeston, Mo

17. (a) Burial (b) Date thereof May 8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo

18. (a) Signature of funeral director Edwin Ellis

(b) Address Sikeston, Mo

19. (a) 7-5-40 (b) Wm H. Pershall
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott

(c) City or town Sikeston, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. Mill St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
1940 year. 8:15 hour _____ minute _____ P. M.

21. I hereby certify that I attended the deceased from 3-19-40
_____ 19. to 5-3-40 19. _____

that I last saw him alive on _____ 19. _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Cardiac
Due to Valvular Disease

Due to Chronic Hypertension

Other conditions Septic Oral Cavity
(Include pregnancy within 3 months of death)

Duration

7

PHYSICIAN

Major findings:
Of operations _____

Of autopsy A2W

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? 142

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

23. Signature Thomas C. McClure (M. D. or other)

Address Sikeston, Mo. Date signed 6-7-40

RECORDING BACK LINK-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. 2,

District File Number 740-1214

Date Filed 7/8/40

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, on May/5/40

....., Registered Apprentice No.....
working under my personal supervision.

Signed William Ellis

Licensed Embalmer No. 3469

P. O. Address Bellevue, Va

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.