

No. 2
1-12-40
17-39
X23159

FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

NR Lumber
State File No. 3341

Registration District No. 533

Primary Registration District No. 3027

Registrar's No. 9

1. PLACE OF DEATH:
 (a) County Macon
 (b) City or town Macon
 (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 _____ years, months or days

3. (a) PRINT FULL NAME Cap A. Jackson
 3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Stella Jackson 6. (c) Age of husband or wife if alive undisclosed years
 7. Birth date of deceased Jan 9-1866 (Month) (Day) (Year)

8. AGE: Years 75 Months - Days 6 If less than one day hr. _____ min. _____

9. Birthplace Macon Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation Horse trainer

11. Industry or business _____

12. Name Sylvain Jackson
 13. Birthplace Ohio (City, town, or county) (State or foreign country)
 14. Maiden name Eizabeth Sherman
 15. Birthplace Douglas (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Cap A Jackson
 (b) Address Macon

17. (a) burial (Burial, cremation, or disposal) (b) Date thereof Jan 14/41 (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn cem

18. (a) Signature of funeral director Albt. Skinner

(b) Address macon mo

19. (a) 2/24/41 (Date received local registrar) (b) Seola Hendon (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO. (b) County Macon
 (c) City or town Macon (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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14 year 1941 hour 12 minute 15 P M.

21. I hereby certify that I attended the deceased from _____, 1940 to Jan 14, 1941;
 that I last saw him alive on Jan 14, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis
 Due to Cerebral Arterio Sclerosis
 Duration 2 days
 Due to _____

Other conditions 83 lb
 (Include pregnancy within 3 months of death)

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? _____

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

23. Signature J F Turner (M. D. or other)
 Address Macon, Mo Date signed 1/28/41

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

132

6/3/2

RECEIVED

District Health Officer No. 10

District File Number 2-41-328

Date Filed FEB 14 1944

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 *George Shile*

Licensed Embalmer No. 4066

P. O. Address *Mason, Ill.*

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, fact should be so stated above.