

FILED MAR 11 1943

Registration District No. 38

Primary Registration District No. 3006-5-1-20

State File No. \_\_\_\_\_  
Registrar's No. 25

1. PLACE OF DEATH:  
(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
101 N. 3rd St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 60 years (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Boone  
(c) City or town Columbia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 101 N. 3rd St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CLARENCE JACKSON  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 2/2/43 day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Magge Jackson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ 1882  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2/1/43 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him alive on 2/2/43 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death Stroke, Parul.  Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
About 60 - - - hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Boone Co. Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired

PHYSICIAN \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy N

MOTHER FATHER  
12. Name Unknown  
13. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Manuel Jackson  
(b) Address Columbia Mo.  
17. (a) Burial (b) Date thereof 2-3-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oliver's Cemetery  
18. (a) Signature of funeral director Street & Parker  
(b) Address Columbia Missouri  
19. (a) 2-4-43 (b) Edna H. Barber  
(Date received local registrar) (Registrar's signature)

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. Bradford (M. D. or other) \_\_\_\_\_  
Address Columbia Mo Date signed 2/4/43

1230

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

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

*Stuart P. Parker*

Licensed Embalmer No.

*2900*

P. O. Address

*Columbia, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. J-796

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(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 \_\_\_\_\_ 60 yrs.  
years, months or days)

3. (a) PRINT FULL NAME Clarence Jackson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased abt 1880  
(Month) (Day) (Year)

8. AGE: Years abt 60 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 3-27-43 (b) E. John H. Barth  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone  
(c) City or town Columbia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 101 N. 3rd St  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
that I saw him/her alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral stroke

Due to \_\_\_\_\_

Due to Cerebral Hemorrhage

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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? Columbia Boone Mo  
(City or town) (County) (State)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
In the Home  
While at work? Retired (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature H. B. Bradford (M. D. or other) \_\_\_\_\_  
Address Columbia Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

