

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

32015

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

File No.

Registered No. **19385**

2. FULL NAME

Isiah Jackson alias John Smith

(a) Residence. No. **911A N. Jefferson St.** Ward.
(Usual place of abode)

Sl. Ward) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX **Male** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**

5a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **6/19/1890**

7. AGE YEARS **37** MONTHS **3** DAYS **26** If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **laborer**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Missouri**
(STATE OR COUNTRY)

10. NAME OF FATHER **Sam Jackson**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Missouri**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Diana Brown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Missouri**
(STATE OR COUNTRY)

14. INFORMANT **Mamie Brown Jackson**
(Address) **911 A N. Jefferson**

15. FILED **351 22 1927** **max b. farrell** Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 18 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 14 1927** to **Oct 14 1927**, and that I last saw him alive on **Oct 14 1927**, and that death occurred, on the date stated above, at **1 AM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
107A

CONTRIBUTORY (SECONDARY) **107A**

18. WHERE WAS DISEASE CONTRACTED **at home**
IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? **no** DATE OF **2**

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**
(Signed) **Wm. C. Muehl, M.D.**
X-18, 1927 (Address) **2335 Franklin**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Washington, D.C.** DATE OF BURIAL **10/23 1927**

20. UNDERTAKER **Russell and Co.** ADDRESS **272 1/2 Pine**

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

