

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... (No. **Peoples Hospital**)

File No. **35092**
Registered No. **10072**
St. Ward)

2. FULL NAME

Julia Jackson
(a) Residence, No. **3217 S. Stanton** St., **M** Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred **45** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **about 1868**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 60 — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Paundress**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Robertsville**
(STATE OR COUNTRY) **Mo**

10. NAME OF FATHER **Not Known**

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

12. MAIDEN NAME OF MOTHER " "

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

14. INFORMANT **Walter Roberts**
(Address) **3217 Stanton Ave**

15. FILED **Mar 6 1928**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

9
16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 9 1928**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 9 1928** to **Oct 9 1928**
I last saw him alive on **Oct 9 1928**, and that death occurred, on the date stated above, at **Peoples Hospital**

THE CAUSE OF DEATH WAS AS FOLLOWS:

Mitral Insufficiency
92.4 (duration) **2** yrs. mos. ds.
97
CONTRIBUTORY Arterio-Sclerosis
(SECONDARY) (duration) **2** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? **NOT AT PLACE OF DEATH**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....
WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **W. M. B. Ager** M. D.
Oct 16 1928 (Address) **3424 G. A. St.**

*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 **Greenwood Cemetery** DATE OF BURIAL **10/13 1928**

20. UNDERTAKER **A. S. Williams** ADDRESS **3232 Pine St.**

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.

PERMANENT RECORD

1871

1871

1871

1871

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