

REC'D APR 15 1939

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

11087
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 400
(b) Township Frank Primary Registration District No. 5553B Registered No. 67
(c) City _____ (d) Street No. to Home _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 460 Joseph Miller
Jackson to Home (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-22-1854

7. AGE YEARS 84 MONTHS 5 DAYS 15 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. unknown
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Ernest Jackson

18. BURIAL, CREMATION OR REMOVAL Green Lawn DATE Mar 10, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wetter Air
to Mo

20. FILED 3-10-1939 William T. Fields Local Registrar. 312

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1939, to 3-7, 1939
last saw him alive on 3-6, 1939. Death is said to have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

Senile debility

Date of onset

Other contributory causes of importance: 162

Name of operation _____ Date of _____
What test confirmed diagnosis Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____ (Signed) J. H. Greene, M. D.

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.

WHILE I LABEL, WITH EMPLOYING INSTITUTION THIS IS A PERMANENT RECORD

435

3
1

0
9
0

OCCUPATION
FATHER
MOTHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.