

Registration District No. 3001

Primary Registration District No. 3001

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.

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville Mo

(c) Name of hospital or institution: 615 East Elm St *v*  
(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

8. (a) PRINT FULL NAME Maggie Cason. 250

8. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. \_\_\_\_\_

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Jimmie Cason

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

7. Birth date of deceased March 9 1874  
(Month) (Day) (Year)

8. AGE: Years 55 Months 9 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House Maid

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

MOTHER FATHER

12. Name Mose Jackson

18. Birthplace Howard County Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Jackson (State or foreign country)

15. Birthplace Howard County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lucy Jackson

(b) Address Kirksville Mo.

17. (a) Adair Co. Mo. (b) Date thereof 11-29-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Doc Riley

(b) Address Kirksville, Mo

19. (a) Nov 30/39 (b) Spencer L. Freeman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Kirksville  
(If outside city or town limits, write "RURAL")

(d) Street No. 615 East Elm St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 27  
year 1939 hour 11:50 minute P. M.

21. I hereby certify that I attended the deceased from admit  
attend - dead on arrival  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
cerebral hemorrhage

Due to fall down staircase  
at home

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

Other conditions (includes pregnancy within 3 months of death) 186

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) accident

(b) Date of occurrence 11-26-39

(c) Where did injury occur? Kirkville, Adair, Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In Home  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury Fall

23. Signature S. D. Davis (M. D. or other) D. O.  
Address Kirkville, Mo Date signed 11-29-39

RECEIVED

District Health Officer No. 10

District File Number 12-39-2175

Date Filed DEC 11 1939

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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.**