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

Do not use this space.

10965

1. PLACE OF DEATH
County Howell — Registration District No. 3824
Township — Primary Registration District No. 4227
City West Plains Mo (No.) — St. — Ward)
File No. 19
Registered No.

2. FULL NAME Samuel Webb Jackson

(a) Residence. No. — St., — Ward.
(Usual place of abode) (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.

APR 23 1931

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Ma	Wht	married

5a. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Rose Jackson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 7 - 1

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	57			

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

9. BIRTHPLACE (CITY OR TOWN) Annapolis, Iron
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Jno. Jackson
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Missoure
12. MAIDEN NAME OF MOTHER Jane Cravens
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missoure

14. INFORMANT Mr. Elmer Jackson
(Address) Caulfield, Mo

15. FILED 1-28-1931 O. A. Heinrich REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-27- 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan ..., 1931, to Jan 27, 1931, that I last saw h... alive on 1-25- 1931 and that death occurred, on the date stated above, at 4:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (SECONDARY) Pyorrhea

(duration) ...yrs. ...mos. ...ds.

18. WHERE WAS DISEASE CONTRACTED? Oneall Mo
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) R. E. Hogue, M. D.
1-28-1931 (Address) West Plains Mo.

*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	DATE OF BURIAL
Piedmont, Mo	1-28-1931
20. UNDERTAKER McFarland's	ADDRESS West Plains Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH. County Howell Registration District No. 384 File No. 1096-C
Township Primary Registration District No. 4227 Registered No. 19
City West Plains (No. , St. Ward)

2. FULL NAME Samuel Webb Jackson

(a) Residence. No. St., Ward.
(Usual place of abode) (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

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 7 1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	57	7	18	

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

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

PARENTS

10. NAME OF FATHER

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
(Address)

15. FILED 1-28-1931 O. A. Heinrichs REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1931

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY