FEB 2? 1929

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

Do not use this space.

7809

1. PLACE OF DEATH —
County Dr Travegio (?)
Township Randolph
City Cantwell (No. ______ St. ______ Ward)

Registration District No. 779
Primary Registration District No. 6024a

File No. ______
Registered No. ______

2. FULL NAME Thomas M 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)
Male	W	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 14 – 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	69		19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lawyer
(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) Kentucky

PARENTS
10. NAME OF FATHER G. W. Jackson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ______
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Rebecka Ford
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ______
(STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs T. M. Jackson
(Address) Cantwell Mo.

15. FILED 2-5-1929 R B Lister
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 2, 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Feby 2, 1929, that I last saw h___ alive on Feby 2, 1929, and that death occurred, on the date stated above, at 11:25 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82A 118 74 a
(duration) ______ yrs. 3 mo mos. ______ ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) ______ yrs. 1 mos. X 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) Edw. C Rohrbach, M. D
2/4, 1929 (Address) Flat River 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 Salem Cemetery
DATE OF BURIAL Feb. 5, 19__

20. UNDERTAKER C. Z. Boyer
ADDRESS Desloge Mo

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