

FLORIDA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County _____ District No. _____ State File No. _____
 Precinct _____ Precinct No. _____
(Write name, not number)
 Inc. Town _____ City or Town No. _____ Registered No. _____
 City _____ No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in _____ or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Emilia M. Jackson
 (a) Residence: No. *1726* _____ St., _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Colored* 5. Single, married, widowed or divorced (write the word) *Infant*
 5a. If married, widowed or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) _____

7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min. *2*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, sawmill, 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) *Jacksonville Fla.*
(State or country)

13. NAME *E. J. Jackson*

14. BIRTHPLACE (city or town) _____
(State or country)

15. MAIDEN NAME *Maaly Jackson*

16. BIRTHPLACE (city or town) *Sumter Co. Fla.*
(State or country)

17. INFORMANT *E. J. Jackson*
(Address)

18. BURIAL, CREMATION, OR REMOVAL Place _____ Date _____ 19 _____

19. UNDERTAKER _____
(Address)

20. FILED _____, 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) *Oct 20 19 37*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h_____ alive on _____, 19____, death is said to have occurred on the date stated above, at _____ m.

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

Date of onset

Contributory causes of importance not related to principal cause:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) _____, M.D.

(Address) _____

Local Registrar.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

