

OREGON STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Dr Kesson 549
State Registered No. _____

1 PLACE OF DEATH

County Jamez State Or Locality Registered No. 401
Township _____ or Village _____
City Eugene No. 532 9 15th St. _____ Ward _____
(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME

Jackson, Nell
(a) Residence No. Eugene St. _____
(Usual place of abode)
Length of residence in city or town where death occurred 33 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male **4 COLOR OF RACE** White **5 Single, Married, Widowed or divorced (write the word)** married

5a If married, widowed or divorced
HUSBAND of Mrs. Miriam Paill
(or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) Dec 8 - 1876

7 AGE
Years 102 Months 00 Days 16
If less than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Horticulturist
(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) Tampa Co., Fla.

10 NAME OF FATHER J. A. Paill

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs. Lulu P. Miller
(Address) Talent, Ore.

15 Filed Jul 10 1929 With Kesson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1928

17 I HEREBY Certify, That I attended deceased from Dec 10 1928, to Dec 24 1928, that I last saw him alive on Dec 24 1928, and that death occurred on the date stated above, at 12-24-28 m.

The **CAUSE OF DEATH*** was as follows:
Cerebral Hemorrhage
with resulting Paralysis
(duration) yrs. mos. 6 days

CONTRIBUTORY Arteriosclerosis
old age (Secondary) (duration) yrs. mos. days

18 Where was disease contracted _____
if not at place of death? _____

Did an operation precede death? No Date of _____
For relief of what condition? _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical
(Signed) S. M. Kesson M. D.
Dec 27, 1928 (Address) Eugene, Ore.

* State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old P. O. F. **DATE OF BURIAL** Dec 27 1928

20 UNDERTAKER Marion F. ... Eugene, Ore.
ADDRESS _____

VERY IMPORTANT. See INSTRUCTIONS ON BACK OF CERTIFICATE.