

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

Do not use this space.

26866

1. PLACE OF DEATH

County J. Hall
Township Barren
City Mayville

Registration District No. 259
Primary Registration District No. 4158

File No.
Registered No.
St. Ward)

2. FULL NAME

Annie Lois Jacobs

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 07.30.18.71

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 10 11 30

8. OCCUPATION OF DECEASED Housework
(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) DeKalb Co Mo

10. NAME OF FATHER Ben Jacobs

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Gen. Mo

12. MAIDEN NAME OF MOTHER Paroline

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Indiana

14. INFORMANT Harrison Jacobs
(Address) Emery, Mo

15. FILED Sept 11, 1927 J. J. Phelps
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 10, 1927

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1926 to September 10, 1927
that I last saw h. ET alive on September 10th, and that death occurred, on the date stated above, at 1P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
82A 79A 157A (duration) yrs. mos. 12Hrs.
CONTRIBUTORY Hydrocephalus probably
(SECONDARY) from early Infantile meningitis.
(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) J. W. Johnson M. D.
9/11, 1927 (Address) Mayville, Missouri.

*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 Oak Grove DATE OF BURIAL 9/12 1927

20. UNDERTAKER J. W. Wain ADDRESS Mayville, Mo

This form should be filled out by the physician or other person who attended the deceased. It should be filled out in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

