

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.

JUN 4 1930

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

Do not use this space.

15204

1. PLACE OF DEATH
 County Adair Registration District No. 4
 Township _____ Primary Registration District No. 3001
 City Kirkville (No. _____) St. _____ Ward _____

2. FULL NAME A. H. Jacobs
 (a) Residence No. _____ St. _____ Ward Woodbine Iowa
 (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 Male 4. COLOR OR RACE White 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) 11-22-1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>45</u>	<u>5</u>	<u>22</u>	

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

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

PARENTS

10. NAME OF FATHER <u>L. J. Jacobs.</u>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Ohio</u> (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER <u>Leona Willard</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Ky.</u> (STATE OR COUNTRY)

14. INFORMANT Mrs. D. A. Watson
 (Address) Woodbine Iowa

15. FILED 5/16, 1930 C. Becker
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-14-1930

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to May 14, 1930, that I last saw him alive on May 14, 1930, and that death occurred, on the date stated above, 11:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-pneumonia

1928
 (duration) _____ yrs. _____ mos. 4 ds.

CONTRIBUTORY Fracture of hip -
 (SECONDARY) (duration) _____ yrs. 1 mos. 14 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH From open reduction of fracture

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Apr. 27, 1930

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Carl W. Kohler, M. D. O
 (Address) Kirkville, 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 Woodbine Iowa DATE OF BURIAL 5-17 1930

20. UNDERTAKER De Riley ADDRESS Kirkville

1930 - 5 - 14
1884 - 11. 22

45 - 5 - 22

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Adair
Township
City Hicksville (No.) St. Ward)

Registration District No. 4
Primary Registration District No. 3001

File No. 15204
Registered No. 74

2. FULL NAME

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) 28

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.

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)

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 Oct 7 1930 Mrs O/H Reeper REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 14 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Supplementary
Bronchitis pneumoniae
practically caused - by trying to reduce a sprained contraction - ambulance which came from a fall in 1929 - causing
fracture of hip
paralysis in lower extremities
Happened in Woodbine, Iowa

18. WHERE WAS DISEASE CONTRACTED Mar 28 1930
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) 65 141, 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

20. UNDERTAKER ADDRESS

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

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