

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

Do not use this space.

19472

1. PLACE OF DEATH

County Jackson Registration District No. 300
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. 5501 Holmes St.) St. _____ Ward _____

File No. _____
 Registered No. 2467

2. FULL NAME

Mildred Jacobs
 (a) Residence. No. 5501 Holmes St. St. 6 Ward _____
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 27, 1917.		
7. AGE	YEARS 12	MONTHS 7
	DAYS 16	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work school (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Kansas

PARENTS	10. NAME OF FATHER Israel Jacobs
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Russia
	12. MAIDEN NAME OF MOTHER Jeanette Milgram
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Missouri

14. INFORMANT Israel Jacobs
 (Address) 5501 Holmes St.

15. FILED 9/13 30 M. M. Brown
 19 30 REGISTRAR Brown

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-12 1930
 17. I HEREBY Deputy Coroner CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental Automobile
fracture, T12-13

LIOM (duration) yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 1880 (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy of Inspecter
6/12 (Signed) Shawley M.D. (Address) Deputy Coroner

*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 **Rose Hill Cemetery** DATE OF BURIAL **6-13-30**

20. UNDERTAKER **J.P. Louis, Funeral Director, City.** ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

