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

Do not use this space.

28925

File No. .....

Registered No. 192

1. PLACE OF DEATH

County: Vernon

Township: Washington

City: ..... (No. ..... St. ..... Ward)

Registration District No. 875

Primary Registration District No. 6162

2. FULL NAME: David Jacoby

(a) Residence. No. State Hosp #3 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. 5 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: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): D.R. - 1886

7. AGE: Years 44 | Months DK | Days DK | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): —
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Gibson Jacoby

11. BIRTHPLACE OF FATHER (CITY OR TOWN): —
(STATE OR COUNTRY): Pa

12. MAIDEN NAME OF MOTHER: Flonnie McConnell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): —
(STATE OR COUNTRY): W Va

14. INFORMANT: State Hosp Record
(Address): Nevada Mo

15. FILED 9/6/ 1930 E. R. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 17 1930

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1930 to Aug 17, 1930 that I last saw him alive on Aug 16, 1930, and that death occurred, on the date stated above, at 2:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gen'l Paralysis Insane (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Syphilis (duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: 170

IF NOT AT PLACE OF DEATH: unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Lab

(Signed) E. H. Cox, M. D.

8-18, 1930 (Address) Nevada Mo

*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: Deepwood Cemet — DATE OF BURIAL: 8/17/1930

20. UNDERTAKER: Fenry Funeral Home — ADDRESS: Nevada

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.

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