

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.

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

35684

Do not use this space.

1. PLACE OF DEATH
 (a) County Cape Girardeau Registration District No. 125
 (b) Township " Primary Registration District No. 3009
 (c) City " (d) Street No. St. Francis Hospital St. "
 (If death occurred in hospital or institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S. if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Joseph J. Jansen
 (a) Residence, No. Leffroy Mo St. Leopold Mo.
 (Usual place of abode; if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 7-1939

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	0	0	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct-7-1939

22. I HEREBY CERTIFY, That I attended deceased from 10/7 1939 to 10/8 1939
 I last saw him alive on 7/8 1939. Death is said to have occurred on the date stated above, at 10 a.m.
 The principal cause of death and related causes of importance were as follows:
Pumature birth
cause unknown

Other contributory causes of importance: 154

Name of operation Autopsy Date of no
 What test confirmed diagnosis Autopsy Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) O. Seaborg M. D.
 (Address) Cape Girardeau

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape Girardeau

FATHER

13. NAME Jacob L. Jansen
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Leopold Mo

MOTHER

15. MAIDEN NAME Mary Holweg
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Leopold Mo

17. INFORMANT (ADDRESS) Jacob L. Jansen
Leopold Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Leopold Mo DATE Oct 9 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Welthaus Under
Cape Girardeau Mo

20. FILED 10-7-39 Jm. Thompson
 Local Registrar.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.