

FILED MAY 17 1940

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

14144
Do not use this space.

1. PLACE OF DEATH
 (a) County Andrew, Registration District No. 13
 (b) Township..... Primary Registration District No. 4010 Registered No. 17
 (c) City Savannah, (d) Street No. Dr. Nichols Sanatorium 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 212 Sarah Rodalia Jacobs,
 (a) Residence, No. 2 St. Hayesville, Iowa,
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed,
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martin S. Jacobs,
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 12, 1862
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 8 9

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Keokuk County, Iowa,

FATHER 13. NAME Homer M. Beall,
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Unknown,

MOTHER 15. MAIDEN NAME Lucretia Utterback
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Indiana,

17. INFORMANT (ADDRESS) Miss Lena Jacobs, Box 26, Hayesville, Iowa,

18. BURIAL, CREMATION, OR REMOVAL PLACE Hayesville, Iowa DATE April 21st, 1940

19. FUNERAL DIRECTOR (ADDRESS) Frank A. Bowman, Savannah, Missouri.

20. FILED Apr. 21, 1940 Mrs. Jennie Rash Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 21, 1940
 22. I HEREBY CERTIFY, That I attended deceased from April 14, 1940 to April 21, 1940
 I last saw her alive on April 14, 1940 Death is said to have occurred on the date stated above, at 9:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage 4/21/40
82W
 Other contributory causes of importance:
arteriosclerosis
Senility

Name of operation None Date of
 What test confirmed diagnosis Physiologist's autopsy?

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? Yes
 If so, specify
 (Signed) A. E. Withem, M. D.
 (Address) Savannah, Mo

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.

RECEIVED

District Health Officer No. 11)

District File Number 540-749

Date Filed MAY 16 1940

STATEMENT BY LICENSED EMBALMER

I, Wm. G. Summerfield

Licensed Embalmer No. 3007

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me Apr 21, 1940

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Wm. G. Summerfield

Licensed Embalmer No. 3007

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.)

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town as an ab
(c) Name of hospital or institution: Dr. Nichols Sanat.
(d) Length of stay: In hospital or institution.....
(Specify whether

In this community
years, months or days

3. (a) PRINT FULL NAME

Sarah R Jacobs

3. (b) If veteran,
name war.....

3. (c) Social Security
No.....

4. Sex 7

5. Color or
race w

6. (a) Single, widowed, married,
divorced w

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if
alive..... year

7. Birth date of deceased.....

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

77

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (b)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County -
(c) City or town Hayesville
(If outside city or town limits write "RURAL")
(d) Street No.....
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr. day 21-40
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
19....., to..... 19.....;
that I last saw him..... alive on..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral hemorrhage
Carcinoma inner corner
left eye & left side of nose (met.)

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Arteriosclerosis
Senility - 52

Major findings:
Of operations.....
Of autopsy.....

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

23. Signature A. E. Metheny
While at work..... (Specify type of place) (e) Means of injury.....
Address..... Date signed.....

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

