

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

21578
Do not use this space.

FILED JUL 12 1940

1. PLACE OF DEATH *2*
(a) County *Cole* Registration District No. *215*
(b) Township *Liberty* Primary Registration District No. *5295*
(c) City *Jac. Mo.* (d) Street No. _____ 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 *100* ANNIE TAUBE
(a) Residence, No. *Jac. Mo.* St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 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 *Herman Taube*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 28, 1900*

7. AGE YEARS *40* MONTHS *3* DAYS *1* If LESS than 1 day, _____ hrs. or _____ min.

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

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) *New York State*

FATHER 13. NAME *Unknown* 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Unknown* 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT *Herman Taube* (ADDRESS) *Jac. Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Jac. Mo.* DATE *July 1, 1940*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *John F. McDonald*
Jefferson Cit. Mo.

20. FILED *July 19, 1940* *Jacobus Land* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 29, 1940*

22. HEREBY CERTIFY, That I attended deceased from *Coroner's Case* to _____, 19____
I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at *2 P.* m.
The principal cause of death and related causes of importance were as follows:
Accidentally shot by a .22 caliber Rifle. Date of onset *194*

Other contributory causes of importance: *None*

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *Accident* Date of injury *June 29, 1940*
Where did injury occur? *Jac. Mo.* (Specify city or town, county, and State)
Specify whether it occurred in industry, in home, or in public place. *In Home*

Manner of injury *shot by a .22 rifle*
Nature of injury *shot in left side of face*

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify _____
(Signed) *Fran J. Nichols* Coroner, M. D.
Macone Mo. (Address)

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.....

John F. Heinrichs

.....
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.