DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21970

Registration District No. 41 | Primary Registration District No. 2002 | Registrar's No.

1. PLACE OF DEATH:

(a) County: Jasper

(b) City or town: Joplin (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Freeman Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 11 Days (Specify whether years, months or days)

In this community: Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Lawrence

(c) City or town: Sarcoxie, "RURAL" (If outside city or town limits, write "RURAL")

(d) Street No.: Route # 2. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Grace Myrl Jacobs 212

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

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Raymond Jacobs

6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: Sept 25, (Month) (Day) 1910 (Year)

8. AGE: Years	Months	Days	If less than one day
29	8	7	hr. ____ min.

9. Birthplace: Lawrence County, (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: ____

MOTHER FATHER

12. Name: Charles E. Sharon

13. Birthplace: (City, town, or county) Ind. (State or foreign country)

14. Maiden name: Nancy C. Whaley

15. Birthplace: (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature: Raymond Jacobs

(b) Address: Route # 2, Sarcoxie, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-3-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Sarcoxie, Mo.

18. (a) Signature of funeral director: Ed. C. Ulmer

(b) Address: 1208 Garrison, Carthage, Mo.

19. (a) 6-4-40 (Date received local registrar) (b) Ed D Jamison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 2, day ____ year 1940 hour 12: minute 40 P.M.

21. I hereby certify that I attended the deceased from May 25, 1940, to June 2, 1940; that I last saw h. alive on June 1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia	
Due to: Inhalation of Ether	
Due to: Appendicitis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: Appendicitis, acute Salpingitis, left sub acute

Of autopsy: ____

PHYSICIAN — Underline the cause to which death should be charged statistically

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? (Specify type of place)

While at work? ____ (e) Means of injury: ____

23. Signature: Leroy Simmons (M.D.)

Address: Sarcoxie, Mo Date signed June 2, 1940

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 — 1 X19511

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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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.....2222

P. O. Address.....Carthage

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.

S. No. 2B
M—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21970

Registration District No. 411 Primary Registration District No. 2002 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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.

3. (a) PRINT FULL NAME Grace Myrl Jacobs
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 29 Months 8 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Inhalation Ether	
Due to appendectomy	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations appendicitis acute
Salpingitis left sub acute
Of autopsy puerperal
no recent delivery or abortion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 2 years
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Leroy Simmons M.D. (M.D. or other)
Address Sarcoxie Mo. Date signed