

MARGIN RESERVED FOR BINDING

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23004

State File No. _____

Registration District No. 853

Primary Registration District No. 4519

Registrar's No. 8

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Newtown Mo
(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 ✓
In this community about 15 hrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Page O. Jacobson 217
3. (b) If veteran, name war _____ 3. (c) Social Security 373-05-5366

4. Sex male 5. Color or race Whit
6. (b) Name of husband or wife Clair 6. (c) Age of husband or wife if alive 25 years
7. Birth date of deceased Aug 29 1913
(Month) (Day) (Year)

8. AGE: Years 26 Months 9 Days 5 If less than one day hr. min.

9. Birthplace Sweden, Stockholm
(City, town, or county) (State or foreign country)

10. Usual occupation Experimental Engineer 7

11. Industry or business Chrysler Corp. 7

12. Name E. T. Jacobson 7

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

14. Maiden name Erma Bernholm 7

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

16. (a) Informant's own signature Clair E. Jacobson

(b) Address 18688 Indiana Detroit Mich

17. (a) removal (Burial, cremation, or removal) (b) Date thereof June 4 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Detroit, Mich.

18. (a) Signature of funeral director Judd & Payne

(b) Address Newtown Mo

19. (a) July 10 1940 (b) Mrs. Ruth Tucker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich (b) County Wayne
(c) City or town Detroit
(If outside city or town limits, write "RURAL")
(d) Street No. 18688 Indiana
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 16 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3rd
year 1940 hour 3:45 minute _____ A. M.

21. I hereby certify that I attended the deceased from 9:20 P.M.
June 2, 1940, to 3:45 A.M., 1940
that I last saw him alive on June 3 1940 12:30 A.M., 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Acute intestinal toxemia

Due to Acute dilatation of stomach

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

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? _____

768 (Specify type of place) (e) Means of injury

23. Signature G. A. Dale D.O. (M. D. or other)

Address Newtown, Mo. Date signed June 3.

50M-5-17-39
Rev. 5-17-39
U.S. GOVERNMENT PRINTING OFFICE

12072

JAN 19 1946

MAR 1 1946

RECEIVED

District Health Officer No. 10

District File Number 7-40-1433

Date Filed JUL 15 1946

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 T. Howard Gidd

Licensed Embalmer No. 52140

P. O. Address Newtown, Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23004

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 85-3

Primary Registration District No. 45-19

Registrar's No. 8

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

1. PLACE OF BIRTH:

(a) County Sullivan
(b) City or town Newton, Mo.
(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)

3. (a) PRINT FULL NAME Tage O. Jacobson

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex m 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 26 Months 9 Days 5 If less than one day hr min.

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) (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)

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

CERTIFICATION

20. DATE OF DEATH Month June day 3 year 1967 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac

Failure

Due to acute intestinal

toxemia

Due to acute dilatation of

stomach

Other conditions (Include pregnancy within 3 months of death)

Major findings: acute intestinal

toxemia due to

botulism probably

from meat

not eaten

22. If death was due to external cause, list in the following:

(a) Accident, suicide or homicide (specify)

(b) Date of occurrence The poison containing

food was not known

(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?

While at work (Specify type of place) (e) Means of injury

23. Signature G. A. Dale M.D. (Other)

Address Newton, Mo.

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-23004