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SEP 3 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
GIVEN SEP 3 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29617
Registrar's No. 1585

Registration District No. 784

Primary Registration District No. 200

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2400 S. Blvd
(If rural, give location)
(e) If foreign born, how long in U. S. A? 40 years.

3. (a) PRINT FULL NAME Michael Jacobich

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

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife widowed 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased 4 28 '83
(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation unemployed

11. Industry or business _____

12. Name Michael Jacobich

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

14. Maiden name Anna Milich

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

16. (a) Informant Koch, wife records
(b) Address Koch, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/40
(Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Charles D. Co.
(b) Address 1716 S. Jefferson Ave.

19. (a) AUG 20 1940 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 18
year 40 hour 7 minute 43 P.M.

21. I hereby certify that I attended the deceased from Aug 17, 1940, to Aug 18, 1940.
that I last saw him alive on Aug 17, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration 5 yrs

Due to _____
Due to 23a

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? _____

While at work? 707 (Specify type of place) (e) Means of injury _____

23. Signature William G. [Signature] (M. D. or other) M.D.
Address Koch, Mo Date signed 8/19/40

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

MOTHER FATHER

JAN 18 1944

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 complete the above constitutes grounds for revocation of license.)

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