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Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8010

FILED OCT 27 1940

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri

(c) Name of hospital or institution: St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Catherine Jacobs

3. (b) If veteran, name war Unknown

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 Leonard 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased June 26 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>2</u>	<u>28</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name William O'Heeron

13. Birthplace Newburg New York
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Kinney

15. P. of place Wilkes Berre Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant John C. Layne

(b) Address 3960a Folsom Ave.

17. (a) Removal (b) Date thereof 9-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat River, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) SEP 25 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")

(d) Street No. 2435 S. 18th St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 24,
year 1940 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from September 22, 1940, to September 24, 1940, that I last saw h. or alive on September 24, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid pneumonia

Due to Cardiac Hypertrophy

Other conditions (include pregnancy within 3 months of death) [Signature]

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? _____ (Specify type of place)

(M. D. or other) Samuel Wallace

23. Signature _____ (M. D. or other)

Address 1515 Lafayette Ave. Date signed 9/24/40

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.....

J. G. Sullivan

Licensed Embalmer No. 1122

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, fact should be so stated above.