

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

BUREAU OF THE CENSUS
FILED OCT 13 1941

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Mary's
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 days**
(Specify whether years, months or days)
 In this community **2 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Dakota South** (b) County **999**
 (c) City or town **Aberdeen** **39**
(If outside city or town limits, write "RURAL")
 (d) Street No. **0**
(If rural, give location)
 (e) Citizen of foreign country? **No**
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Mrs Agnes Jacobs

3. (b) If veteran,

name war **no**

3. (c) Social Security

No. **none**

4. Sex **Fe**

5. Color or race **Wh**

6. (a) Single, widowed, married, divorced **2 Widowed**

(b) Name of husband or wife **Mathew Jacobs**

6. (c) Age of husband or wife if alive **1885** years

7. Birth date of deceased **Sept. 13**
(Month) (Day) (Year)

8. AGE: **55** Years

Months **11**

Days **23**

If less than one day
 hr. _____ min.

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

10. Usual occupation **at home**

11. Industry or business _____

12. Name **Joseph Ellery**

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

14. Maiden name **Elizabeth Jane Mitchell**

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

16. (a) Informant **Mrs George Chambers**

(b) Address **20 West 66th St. Terrace**

17. (a) **Removal** (b) Date thereof **Sept 12, 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Aberdeen, South Dakota**

18. (a) Signature of funeral director **Mrs C. L. Forster**
 (b) Address **918 Brooklyn Avenue Kansas City**

19. (a) **9/12/41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **10**
 year **1941** hour **10:45 pm** M.

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

that I last saw him alive on **9-10** _____ 19**41** and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized arteriosclerosis**

Due to **Cerebral Ca** **40**

Due to _____

Other conditions **none**
(Include pregnancy within 3 months of death)

Major findings: **Highly degenerated arteries, atherosclerosis**
 Of autopsy **correct**

Duration _____
 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) (e) Means of injury _____

23. Signature **[Signature]**
 Address **1010 Kialla Ave** Date signed **9-11-41**

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 *Wm J. C. Browning*

Licensed Embalmer No. *2724*

P. O. Address *W. C. M. S.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.