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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 2 1942

Registration District No. 83

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10272

Primary Registration District No. 5127

Registrar's No. 275

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

1. PLACE OF DEATH:
(a) County: BUCHANAN
(b) City or town: Washington Twp. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RFD #6 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 (Specify whether years, months or days)
In this community: ABT - 75 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO (b) County: Buchanan
(c) City or town: St Joseph (Rural) (If outside city or town limits, write "RURAL")
(d) Street No.: RFD #6 (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

011 00

3. (a) PRINT FULL NAME: WILLIAM B. JACOBS
3. (b) If veteran, name war: NO
3. (c) Social Security No.: NO
4. Sex: Male
5. Color or race: WH
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Dollie A.
6. (c) Age of husband or wife if alive: 17 years
7. Birth date of deceased: Mar (Month) 17 (Day) 1861 (Year)

8. AGE: Years	Months	Days	If less than one day
80	11	27	hr. min.

9. Birthplace: Columbia (City, town, or county) MO. 0 (State or foreign country)
10. Usual occupation: Retired Bricklayer
11. Industry or business:
12. Name (Father): John Jacobs
13. Birthplace (Father): unk (City, town, or county) MO. 0 (State or foreign country)
14. Maiden name (Mother): unk
15. Birthplace (Mother): unk (City, town, or county) 9 (State or foreign country)
16. (a) Informant: Alfred C. Jacobs
(b) Address: 6202 Washington St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 16 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Auburn Cem
18. (a) Signature of funeral director: Roy Clauser
(b) Address: St Joseph Mo
19. (a) 3-14-42 (Date received local registrar) (b) H. J. Mettlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: March day: 14 year: 1942 hour: 5 minute: 30 A.M.
21. I hereby certify that I attended the deceased from July 3, 1937, to March 14, 1942, that I last saw him alive on March 14, 1942, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	3 days
Due to: Chronic myocarditis + endocarditis	5 yrs
Due to:	
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? (Specify type of place)
While at work? (c) Means of injury:
23. Signature: E. Gross (M. D. or other) MD
Address: 5068 Frederick Ave St. Joseph, Mo Date signed: 3-14-42

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.....

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town.....
(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 years, months or days)
In this community.....

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.....
3. (b) If veteran, name war..... 3. (c) Social Security No.....
4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
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..... Months..... Days..... If less than one day ..... hr. ..... min.
9. Birthplace.....

MEDICAL CERTIFICATION

10. DATE OF DEATH: Month.....day.....
year.....hour.....minute.....M.
11. 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.
Immediate cause of death..... Duration
Due to.....
Due to.....
Other conditions.....
(Contributory within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

10. Usual occupation.....
11. Industry or business.....
12. Name..... } FATHER
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Name..... } MOTHER
15. Birthplace..... (City, town, or county) (State or foreign country)
16. (a) Informant..... (b) Address.....
17. (a) Signature of informant..... (b) Address.....
18. (a) Signature of undertaker..... (b) Address.....
19. (a) Date received by registrar..... (b) Registrar's signature.....

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. 2435
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.

(Licensed Embalmer's Statement on Reverse Side)

20. 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)
(e) Means of injury.....

DISTRICT REGISTRAR'S RECORD

NEGRO BLACK TAX-NAME A PERMANENT

FILE LAYER—ISO-VITAL

. S. No. 2B
DM—8-21-41
I X29288

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. 10272

Registration District No. 85 Primary Registration District No. 5127 Registrar's No.

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: Rural
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William B Jacobs
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: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Nov (Month) 17 (Day) 1862 (Year)
8. AGE: Years 80 Months 10 Days 27 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 14 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia (Lobar)	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 108	
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)
(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY