. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 4 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41637

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1303

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6th St Viaduct (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 43 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St Joseph (If outside city or town limits, write "RURAL")

(d) Street No. Ayrlawn Add. R5 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Roy Jacobs

3. (b) If veteran, name war

3. (c) Social Security No. 491-10-7761

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ethel

6. (c) Age of husband or wife if alive not given years

7. Birth date of deceased April (Month) 11 (Day) 1900 (Year)

8. AGE: Years 43 Months 7 Days 18 If less than one day ___ hr. ___ min.

9. Birthplace St Joseph (City, town, or county) Mo (State or foreign country)

10. Usual occupation not stated

11. Industry or business

FATHER
12. Name James Jacobs
13. Birthplace St Joseph (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Anna Richardson
15. Birthplace Andrew Co. (City, town, or county) Mo (State or foreign country)

16. (a) Informant Ethel Jacobs

(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn Cem

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address St Joseph Mo.

19. (a) 12-1-43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29 year 1943 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from on Nov. 29th, 1943, 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 Multiple fractures of the skull, frontal and right parietal regions, with loss of brain substance and profuse hemorrhage from the cranium.

Due to

Due to

Other conditions Fracture of superior and inferior maxillary bones, compound fracture of right leg. Man was instantially killed

(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy No. While riding in an automobile driven by another

Duration: 1 day

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) Accident 131

(b) Date of occurrence Nov 29-1943

(c) Where did injury occur? St Joseph (City or town) Buch (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? South 6th St. Viaduct. (Specify type of place)

While at work? No (e) Means of injury Automobile

23. Signature H F Mundy (M. D. or other) Coroner

Address 404 So 3d Date signed 12/1/43

(Licensed Embalmer's Statement on Reverse Side)

1283

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 Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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, fact should be so stated above.