

S. No. 2
M-2-43
5-17-39
P-1 X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9103**

FILED APR 1 1944 8

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **2877**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4667 Tesson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4667 Tesson** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Philip H. Jacobi,**
3. (b) If veteran, name war _____ **3. (c) Social Security No.** **702-14-2065**

4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Margaret** **6. (c) Age of husband or wife if alive** **32**
7. Birth date of deceased **March 2 1887**
(Month) (Day) (Year)

8. AGE: Years **57** Months **0** Days **24** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Accountant**
MO. PACIFIC

11. Industry or business _____
12. Name **Philip Jacobi**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Margaret Jacobi**
(b) Address **4667 Tesson**

17. (a) **Burial** **(b) Date thereof** **Mar. 29, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director **Wacker Alderle**
(b) Address **3634 Gravois Ave.**

19. (a) _____ **(b) 1944** **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **26**
year **1944** hour **6:00** minute _____ P. M.
21. I hereby certify that I attended the deceased from **Jan 42** to **March 26** 19**44**
that I last saw him alive on **March 16** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis bro.**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

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 **J. R. Sheridan** (M. D. or other)
Address **2602 So. Grand** Date signed **3-27-44**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Dr. E. K. Sheridan, 2602 S. Grand-Gr. 6619
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Wheeler*.....
Licensed Embalmer No. *3128*.....
P. O. Address..... *Stoughton*.....

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.