

23757

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 14 1944

3147

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

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:
STEVA NURSING HOME - 1310 EAST ARMOUR
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 YEARS
(Specify whether
In this community 2 YEARS 4
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County RAY 89
(c) City or town RICHMOND 1
(If outside city or town limits, write "RURAL")
(d) Street No. 212 WEST MAIN STREET
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. ELIZABETH CROWLEY JACOBS

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MR. ROBERT L. JACOBS 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased SEPTEMBER 17 1862
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	81	10	15	hr. _____ min. _____

9. Birthplace LAWSON MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER
12. Name JOHN CROWLEY
13. Birthplace CLAY COUNTY MISSOURI
(City, town, or county) (State or foreign country)
14. Maiden name ANN FULLER
15. Birthplace CLINTON COUNTY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant Miss M. J. Brice

(b) Address 800 7th St

17. (a) burial (b) Date thereof Dec 19 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jackson MO

18. (a) Signature of funeral director O. H. Newcomer Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 8-1-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 29TH
year 1944 hour 5 minute 15 A. M.

21. I hereby certify that I attended the deceased from 5-29 1944 to 7-29 1944
that I last saw her alive on 7-28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia 4 days

Due to Cerebral Hemorrhage 60 day

Other conditions Hypertension
(Include pregnancy within 3 months of death)

Major findings: Of operations GBA
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)
(e) Means of injury _____

23. Signature J. E. Ball (M. D. or other) _____
Address 1102 E 47 Date signed 7/29/44

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

8000

Door left at 1:30
Head Centre Body
1:30 - 5:30

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 *Edgar Horney*

Licensed Embalmer No. 1767

P. O. Address 140 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.