

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X35671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36025

FILED NOV 22 1944

Registration District No. 318

Primary Registration District No.

Registrar's No. 969

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County..... Mad  
(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5514 Pershing Ave  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Rebecca J. Jacobson

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

4. Sex female 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Hugo Jacobson 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased August 5, 1862  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 3 9 hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

12. Name Simon Jacobson (same as married name) 4

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

14. Maiden name Ernestine Bressler

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

16. (a) Informant Ernestine Jacobson

(b) Address 15514 Pershing Ave

17. (a) Burial (b) Date thereof 11/16/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive (Jewish)

18. (a) Signature of funeral director J. F. Bredbeck

(b) Address 4356 Lindell Blvd

19. (a) NOV 22 1944 (b) J. F. Bredbeck  
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14  
year 1944 hour 1 minute P M.

21. I hereby certify that I attended the deceased from Nov. 8  
1944 to Nov. 14 1944  
that I last saw her alive on Nov. 14 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Intestinal Obstruction Duration 6 days

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Or autopsy Replaced appendix - Several Peritonitis

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 Herbert M. Meigs (M. D. or other) MD

Address 508 N. Grand Date signed 11/14/44

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 *John Gauski*  
.....  
Licensed Embalmer No. *3398*  
.....

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.**