

FILED MAR 3 1945
Registration District No. _____

Primary Registration District No. 6178

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan Auncian Twp.

(b) City or town Browning ANNEX

(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 _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan

(c) City or town Browning Mo - Rural P.O. 2
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME JAMES S. JACOBS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8
year 1945 hour 9 minute P. M.

4. Sex male 5. Color or race Wht

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

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

7. Birth date of deceased June 12 1851
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 8th 1945 to one call 19 _____
that I last saw him alive on Feb 8 1945 - 9 PM 19 _____
and that death occurred on the date and hour stated above.

8. AGE: Years 93 Months 8 Days 7 If less than one day _____ hr. _____ min.

Immediate cause of death _____
Bronchial Pneumonia following deep cold.
Due to history of Patient falling & dislocating rt. hip about 2
Due to heavy profuse raw wind about 3 1/2 hours before death

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

9. Birthplace Sullivan County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

Major findings: none
Of operations _____

Of autopsy none

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

11. Industry or business Farming

12. Name Alford Jacobs

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

14. Maiden name Martha Brookshire

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident 135

(b) Date of occurrence about 5:30 PM Feb 8th 1945

(c) Where did injury occur? in home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
fell in house while at the out
While at work? no (Specify type of place) (e) Means of injury fell in floor

16. (a) Informant Claude Jacobs

(b) Address Lunda Mo Rural

17. (a) Burial (b) Date thereof 2-11-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lacust Valley Cem.

18. (a) Signature of funeral director R. K. Bayner Son
(b) Address Galt Mo

19. (a) Feb. 14 1945 (b) Mrs. L. D. Green
(Date received local registrar) (Registrar's signature)

23. Signature Henry W. Lahl (M.-D. or other) _____
Address Portland Mo Date signed 2-10-45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 2-45-380

Date Filed FEB 28 1945

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.....

P. K. Payne Jr.

Licensed Embalmer No.....

3400

P. O. Address.....

Galt

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.

Registration District No. 381

Primary Registration District No. 6178

Registrar's No.

1. PLACE OF DEATH

(a) County Sullivan
(b) City or town Browning Duncan Twp
(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 _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

James S. 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 June 1
(Month) (Day) (Year)

8. AGE: Years 93 Months 8 Day _____
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 1
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ 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 _____
(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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

73le3