

S. No. 2
M-8-43
5-17-39
I X37823

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27340
State File No. _____
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 28 1945

Registration District No. _____ Primary Registration District No. 5435

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

1. PLACE OF DEATH:
(a) County Gasconade
(b) City or town Rural Boonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: His Residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Entire Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Gasconade
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1 1/2 miles South West of Stonyhill
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME AUGUST JACOB
(b) If veteran, name war No
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 31st
year 1945 hour 7 minute 45 AM.

4. Sex Male 5. Color or race White
6. (a) Single widowed married
Advanced widowed
6. (b) Name of husband or wife Emma Jacobs 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased June 20 1866
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 20, 1945 to May 31, 1945
that I last saw him alive on May 30, 1945
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>11</u>	<u>11</u>	_____ hr. _____ min.

Immediate cause of death Cerebral hemorrhage Duration 30 hrs.

9. Birthplace Stonyhill, Missouri.
(City, town, or county) (State or foreign country)

Due to General arteriosclerosis
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation Farming
11. Industry or business Farmer

Major findings: 830
Of operations _____
Of autopsy _____

MOTHER FATHER {
12. Name Benedict Jacob
13. Birthplace unknown Switzerland
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace Unknown Unknown
(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) _____
(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 _____

16. (a) Informant Arthur Jacob
(b) Address New Haven, Missouri. RFD

23. Signature G. W. Feld (M. D. or other) D.O.
Address New Haven, Mo. Date signed 5/31/45

17. (a) Burial (b) Date thereof 6/6/45
(Burial, cremation, or removal) (Month) (Day) (Year)
St. James Cemetery, Stonyhill, Mo.
(c) Place: burial or cremation
18. (a) Signature of funeral director Paul H. Blumer
(b) Address Hermann, Mo.
19. (a) 6/4/45 (b) Mrs. F. B. Dreyer
(Date received local registrar) (Registrar's signature)

1262

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-27-45

APR 5 1946

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 Chas. J. Pope

Licensed Embalmer No. 2552

P. O. Address Hermann, 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.