

Registration District No. **43** Primary Registration District No. **4057**

1. PLACE OF DEATH:
 (a) County Butler
 (b) City or town Quincy
 (c) Name of hospital or institution: Home
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days On 1/1

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Butler
 (c) City or town Quincy
 (d) Street No. Rural #1
 (e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Edmira Katherine Jacobs
 3. (b) If veteran, name war _____ 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife Wm Jacobs 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 14-1863

8. AGE: Years 82 Months 6 Days 10 If less than one day _____ hr _____ min.

9. Birthplace Marissa Ill.
 (City, town, or county) (State or foreign country)

10. Usual occupation Home work

11. Industry or business _____

MOTHER FATHER
 12. Name Wm. Bigland
 13. Birthplace Dont know Ill
 (City, town, or county) (State or foreign country)

14. Maiden name Harriet Logan
 15. Birthplace Dont know Ill
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elaine Cook
 (b) Address Quincy Mo

17. (a) Interd (b) Date thereof 11-25-1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dad Ridge Cem.

18. (a) Signature of funeral director Wm. M. Minter
 (b) Address 27-46

19. (a) 11-27-46 (Date received local registrar) Wm Minter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23
 year 1946 hour 11 minute 15 P M.
 21. I hereby certify that I attended the deceased from 7/10, 1946 to 11/23, 1946
 that I last saw h. ea alive on 11/23, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Semility
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy _____
 162B

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)
 (a) Means of injury _____
 Signature Wallace Selvey (M. D. or other) MD
 Address Campbell Mo. Date signed 11/23/46

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

RECEIVED

District Health Office No. 2,

District File Number 1246-1402

Date Filed 12-5-46

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.....

Licensed Embalmer No.....

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.