

S. No. 2  
OM-543  
v. 5-17-39  
I X36671

19946

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 2 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 17

Registration District No. 372

Primary Registration District No. 4543

1. PLACE OF DEATH:  
(a) County Webster  
(b) City or town Seymour Mo.  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Webster 112  
(c) City or town Seymour Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? Naturalized (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Knute Jacobsen  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. 459-26-0350

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 18  
year 1947 hour 5:40 minute \_\_\_\_\_ A.M.

4. Sex MO 5. Color or race W  
6. (a) ~~Single~~ widowed, married, divorced  
6. (b) Name of husband or wife Maud Jacobsen  
6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased September 26 1876  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
1947 to 9-10-5-12-47 1947  
that I last saw him alive on 5-17 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
70 7 22 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Pulmonary tuberculosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Denmark (City, town, or county) H (State or foreign country)  
10. Usual occupation retired farmer

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 13 B  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Hanse Jacobsen  
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)  
14. Maiden name unknown  
15. Birthplace \_\_\_\_\_ (City, town, or county) 9 (State or foreign country)

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

16. (a) Informant Maud Jacobsen  
(b) Address Seymour Mo.  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21 1947  
(Month) (Day) (Year)  
(c) Place: burial or cremation Seymour Cemetery  
18. (a) Signature of funeral director Kelley, Foxell, Bergna  
(b) Address Seymour Mo.  
19. (a) May 27 (Date received local registrar) (b) Gilbert Jones (Registrar's signature) 313

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 G. G. Beers (M. D. or other) \_\_\_\_\_  
Address Seymour Mo. Date signed 5-24

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

12  
0  
0  
47  
300  
20

47

RECEIVED

District Health Officer No. 61

District File Number 547-582

Date Filed MAY 28 1947

JUN 2 1947

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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 K. K. Kelley

Licensed Embalmer No. 3334

P. O. Address Fordland, Me.

**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.