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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 30 1947

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 22361

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5973

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

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 4 weeks (Specify whether

In this community 4 weeks years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town University City (If outside city or town limits, write "RURAL") 3

(d) Street No. 710 Leland (If rural, give location) 5

(e) Citizen of foreign country? NR (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME ABRAHAM JACOBS

3. (b) If veteran, name war none

3. (c) Social Security No. 498-07-9479

4. Sex male

5. Color or race W.

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

6. (b) Name of husband or wife Ella Glaser Jacobs

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Jan (Month) 18 (Day) 1869 (Year)

8. AGE: Years 78 Months 5 ~~0~~ Days 0 ~~5~~ If less than one day hr. min.

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

10. Usual occupation Sales man

11. Industry or business Eli- Walker D.G.Co.

FATHER

12. Name ********** Jacobs

13. Birthplace Unknown (City, town, or county) (State or foreign country) 9

MOTHER

14. Maiden name Sarah Rosenberg

15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Ella Jacobs

(b) Address 710 Leland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer

(b) Address 4356 Lindell Blvd.

19. (a) JUN 20 [illegible] (Date received local registrar) (b) J. F. Bresick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18 year 1947 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb. 3 1947 to June 18 1947 that I last saw him alive on June 18 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Bronchopneumonia | 2 days |
| Due to Rt. Hemiplegia | 3 days |
| Due to Cerebral Arteriosclerosis | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy Marked Arteriosclerosis - generalized | |

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature H. Scheff (M. D. or other)

Address 607 N. Grand Date signed 6/20/47

Harold Scheff

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

## 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 Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address St. Louis

**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.**