

FILED DEC 16 1947

State File No. \_\_\_\_\_

Registration District No. 309

Primary Registration District No. 6050

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town West Alton  
(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 60 YRS years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County 92 ✓  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL.") 0 ✓  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Jacobs

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John Jacobs 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November 7 1868  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>8</u>	<u>26</u>	_____ hr. _____ min.

9. Birthplace Hanover Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business Own Home

MOTHER FATHER { 12. Name Henry Luehning

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

14. Maiden name Marie Hennagus

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

16. (a) Informant John A. Bocher  
(b) Address West Alton Mo.

17. (a) Burial (b) Date thereof Aug. 5 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Immaculate Concep. Cem.

18. (a) Signature of funeral director John A. Bocher  
(b) Address Alton Ills

19. (a) 8-6-1947 (b) John A. Bocher  
(Date received local registrar) (Registrar's signature) 366

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3<sup>rd</sup>  
year 1947, hour 7, minute 55 P.M.

21. I hereby certify that I attended the deceased from Aug 1, 1947  
1947 to August 3, 1947  
that I last saw her alive on August 2<sup>nd</sup>, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage Duration 1.5 hr

Due to General Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 83A  
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? \_\_\_\_\_

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

23. Signature C. A. Bernard (M. D. or other) \_\_\_\_\_  
Address Postage Plus Store Date signed 8/4/47

67,430

**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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed John A. Hocher  
Licensed Embalmer No. 1842  
P. O. Address Acton Ill

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. 309

Primary Registration District No. 6050

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town West Alton  
(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 60 years (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

Mary Jacobs

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife John Jacobs

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Jan. 7 1877  
(Month) (Day) (Year)

8. AGE: Years 78

Months \_\_\_\_\_

Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Hannover, Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation office work

11. Industry or business own home

MOTHER, FATHER

12. Name Henry Luckning

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

14. Maiden name Marie Hannejos

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

16. (a) Informant Henry Jacobs  
(b) Address West Alton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation Immaculate Conception C.

18. (a) Signature of funeral director J. A. Hohm  
(b) Address Alton, Mo.

19. (a) 8-6-1947 (Date received local registrar) (b) J. W. Prass (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County St. Charles  
(c) City or town West Alton, Mo.  
(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 Do not know

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_, Year 1947, hour \_\_\_\_\_, minute 55 P.M.  
21. I hereby certify that I attended the deceased from 9-15-1945 to 8-2-1947  
that I last saw him alive on 8-2-1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Hemorrhage  
General Arterio Sclerosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration 1 yr  
**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 C. A. Bernard (M. D. or other)  
Address Portage St. St. Louis, Mo. Date signed 5-1-47

SUPPLEMENTAL

42738