

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

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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED JUN 28 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21001

1003

Registrar's No. 5441

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: De Paul Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 5329 Northland Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Leokadya Jakubiak (Jacoby)

3. (b) If veteran, name war _____ 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 Martin Jakubiak 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 4 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	6	10	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name (?) Ryczek

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

14. Maiden name _____

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

16. (a) Informant Theodore Jacoby

(b) Address 5329 Northland Ave.

17. (a) Burial (b) Date thereof 6/15/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) JUN 15 1948 (b) J. F. Bradeck
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
 year 1948 hour 3 minute 35 P. M.

21. I hereby certify that I attended the deceased from April 4, 1948, to June 14, 1948, that I last saw her alive on June 14, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 days

Due to Hypertension

Due to _____

Other conditions HT
(Include pregnancy within 3 months of death)

Major findings: 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? _____

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

23. Signature J. B. [unclear] (M. D. or other) _____

Address Northland Bldg. St. Louis Date signed 6/15/48

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

[Handwritten Signature]
.....
Licensed Embalmer No. *366*
P. O. Address. *[Handwritten 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.