

Registration District No. **310**

Primary Registration District No. **3058**

1. PLACE OF DEATH:

a) County **St. Charles**
 b) City or town **St. Charles**
 (If outside city or town limits, write "RURAL" and name of township)
 c) Name of hospital or institution:
St. Joseph Hospital
 (If not in hospital or institution, write street number or location)
 d) Length of stay: In hospital or institution **17 days**
 (Specify whether years, months or days)
 In this community **17 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Lincoln**
 c) City or town **Elsberry**
 (If outside city or town limits, write "RURAL")
 d) Street No. **Highway B.**
 (If rural, give location)
 e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Magdalena Jacob,
 3. (b) If veteran, name war **none**
 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 **Henry Jacob**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Aug. 5, 1861**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 11 19 hr. min.

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

10. Usual occupation **Housewife (Retired)**

11. Industry or business **Own home**

12. Name **Gross,**

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

14. Maiden name **Marie Giffert,**

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

16. (a) Informant **Mrs. George Ruck,**

(b) Address **Manchester, Mo.**

17. (a) **Burial** (b) Date thereof **7/27/48**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. John Cem. Manchester,**

(a) Signature of funeral director **Schrader Funeral Home,**
Ballwin, Mo.

19. (a) **Aug 2-48-** (b) **Hanna Hamister**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**
 year **1948** hour **4** minute **50** P.M.
 21. I hereby certify that I attended the deceased from **July 8**
 1948, to **July 24** 1948
 that I last saw her alive on **July 24** 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decompensation** Duration _____

Due to **Generalized Atherosclerosis**

Due to **Fractured Rt. Hip**

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy **86W**
18

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? **Mo.**

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

Signature **George R. Sasaki** (M. D. or other) _____

Address **St. Charles Hotel Bldg.** Date signed **7-24-48**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED
District Health Officer No. 9,
District File Number
AUG 9 1948
Date Filed

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.....

Richard Bopp
working under my personal supervision.

Registered Apprentice No. *2*

Signed *Harry F. Schrader*

Licensed Embalmer No. *2091*

P. O. Address *Ballwin Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. Aug
Registrar's No. 148

Registration District No. 310

Primary Registration District No. 2058

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town St Charles
(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 _____ years, months or days)
3. (a) PRINT FULL NAME Magdalene Joseph
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 _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: Aug 5 (Month) (Day) (Year)

8. AGE: 86 Years Months Days (If less than one day, hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (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): Foot. Rt. Hip
(b) Date of occurrence: 7-9-48
(c) Where did injury occur? (Home) Strawberry Mo. (Linn Co.)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
At home - missed last step, walked down stairs.
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature George R. Decker (M. D. or other)
Address St Charles Hotel Bldg Date signed _____

MOTHER FATHER

SUPPLEMENTARY

S-23959