

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

27  
39

FILED OCT 23 1948  
Registration District No. 397

Primary Registration District No. 3063

State File No. \_\_\_\_\_  
Registrar's No. 227

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis Clinton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 6390 Forsyth Blvd.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community..... Years  
years, months or days) (Specify whether

3. (a) PRINT FULL NAME Elizabeth M. Jacobs  
3. (b) If veteran, name war..... No  
3. (c) Social Security No. .... No

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife..... Oscar Jacobs  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased..... April 1 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
63 6 12 hr. .... min.

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

10. Usual occupation Housekeeper

11. Industry or business.....

12. Name William Derkum

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

14. Maiden name Anna Sickinger

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

16. (a) Informant..... Mrs. Edna Weatherly  
(b) Address..... 7315 Murdoch Ave.

17. (a) Burial (b) Date thereof Oct. 16 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Resurrection Cem. C. Holmeister Colonial Mortuary

18. (a) Signature of funeral director.....  
(b) Address..... 6464 Chippewa St.

19. (a) 10-13-48 (b) Gene A. Daphne  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo (b) County..... 96  
(c) City or town..... St. Louis Clinton  
(If outside city or town limits, write "RURAL")  
(d) Street No..... 6390 Forsyth Blvd.  
(If rural, give location)  
(e) Citizen of foreign country?..... No (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Oct. day..... 13  
year..... 1948 hour..... 7 minute..... 00 A.M.

21. I hereby certify that I attended the deceased from..... April 4  
1948, to..... Oct 13, 1948.  
that I last saw her..... alive on..... Oct 13, 1948.  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Cerebral Hemorrhage Duration..... 1 hour

Due to..... Coronary Thrombosis 3 days

Due to..... Diabetes Mellitus years

Other conditions.....  
(Include pregnancy within 3 months of death) 61

Major findings:  
Of operations.....

Of autopsy.....

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..... Gene A. Daphne (M. D. or other) MD  
Address..... 3325 S. Grand Date signed..... 10/13/48

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

Ge9 Daman  
3325 So. Grand Blvd.

---

---

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 *Lewis C. Hoffmann*  
Licensed Embalmer No. *3871*  
P. O. Address *7814 S Broad*

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.

Registration District No. 317 Primary Registration District No. 3063

**1. PLACE OF DEATH:**  
(a) County St Louis Clayton  
(b) City or town Clayton  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

**3. (a) PRINT FULL NAME** Elizabeth M Jacob  
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 April (Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 2 (If less than one day, hr. min.)

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

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 \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

2B  
43880

S-34910