

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24885

State File No.

3696

Registrar's No.

BIRTH NO. **FILED AUG 13 1953**REG. DIST. NO. **149**PRIMARY REG. DIST. NO. **1002**

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

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, write RURAL and give township) Kansas City | | c. CITY OR TOWN Kansas City | |
| c. LENGTH OF STAY (in this place) 32 yrs. | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Krestwoods Medical Hospital | | e. STREET ADDRESS (If rural, give location) 710 5300 Garfield Street 3768 | |
| 3. NAME OF DECEASED (Type or Print) a. (First) EMMA b. (Middle) SEELEY c. (Last) JACOBS | | 4. DATE OF DEATH (Month) (Day) (Year) 7 26 1953 | |
| 5. SEX Fe | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 8-2-1864 |
| 9. AGE (In years last birthday) 88 | | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and State or Foreign Country) Illinois |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME James M. Seeley | |
| 13b. MOTHER'S MAIDEN NAME Nellie Unsell | | 14. NAME OF HUSBAND OR WIFE William L. Jacobs | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT'S SIGNATURE OR NAME Lewis Jacobs, 5012 W. 71st | | ADDRESS | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 4 years II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4200 | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | |
| 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | 22. I hereby certify that I attended the deceased from July 25, 1953 , to July 26, 1953 , that I last saw the deceased alive on July 25, 1953 , and that death occurred at a. m. , from the causes and on the date stated above. | |
| 23a. SIGNATURE T. Reid Jones (Degree or title) M.D. | | 23b. ADDRESS 1107 Bryan St | |
| 23c. DATE SIGNED 7-27-53 | | 24a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal | |
| 24b. DATE 7-28-1953 | | 24c. NAME OF CEMETERY OR CREMATORY Clarence, Mo. Cemetery | |
| 24d. LOCATION (City, town, or county) (State) Clarence, Missouri | | 25. FUNERAL DIRECTOR'S SIGNATURE FREEMAN MORTUARY & CHAPEL, K.C., Mo. | |
| DATE REC'D BY LOCAL REG. 7-27-53 | | REGISTRAR'S SIGNATURE Therelaine Smith | |

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. Reid Jones =
Bryant Bldg. Vi 0848
12:30 - 40

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Clayton Barnes*.....
Licensed Embalmer No. 4793

P. O. Address *K. C., Mo.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.