

FILED NOV 13 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36525**

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **380**

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Palmyra	
c. LENGTH OF STAY (in this place) 6 days		d. STREET ADDRESS (If rural, give location) 310 W. Church	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Alyda b. (Middle) C. c. (Last) Jacobs	4. DATE OF DEATH (Month) (Day) (Year) Oct. 29 1953
--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 6 Aug. 1872	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
----------------------	-------------------------------	---	-------------------------------------	---	------------------------	----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	---	---

13a. FATHER'S NAME A.B. Chambers	13b. MOTHER'S MAIDEN NAME Rachel M. Fleming	14. NAME OF HUSBAND OR WIFE WM. Jacobs
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Iva M. Foster, Bonneville, Wyo.	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 wks.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Cervix & Uterus DUE TO (c)		3-4 mos.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	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 **Sept 1** 19**53** to **Oct 29** 19**53**, that I last saw the deceased alive on **Oct 29** 19**53**, and that death occurred at **10:55 PM**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) Dr.	23b. ADDRESS Palmyra Mo.	23c. DATE SIGNED 11/2/53
-----------------------------------	------------------------------	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 31 Oct. 1953	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) Palmyra, Missouri
---	-------------------------------	--	--

DATE REC'D BY LOCAL REG. 11-4-53	REGISTRAR'S SIGNATURE Dr. E.M. Lucke	25. FUNERAL DIRECTOR'S SIGNATURE Jervis Brothers	ADDRESS Palmyra, Mo.
---	---	---	-----------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED NOV 9 1963
MARION CO. HEALTH DEPT.
DATE FILED NOV 9 1963

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
Student Embalmer

Signed George M. Lewis

Licensed Embalmer No. 4851

P. O. Address Falmouth, 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 this body is not embalmed, fact should be so stated above.