

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42972**
Registrar's No. **5686**

FILED DEC 23 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 002

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) OR TOWN Kansas City	c. LENGTH OF STAY (In this place) 65 yrs.	c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		e. STREET ADDRESS (If rural, give location) 4451 S. Benton	

3. NAME OF DECEASED (Type or Print) a. (First) Cora b. (Middle) M. c. (Last) Jacobs			4. DATE OF DEATH (Month) (Day) (Year) 12 2 1953			
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 21 Aug 1886	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during past year, or if retired, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Nevada Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Willis Foreman	13b. MOTHER'S MAIDEN NAME Lucretia Feeter	14. NAME OF HUSBAND OR WIFE H.R. Jacobs
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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. 486-10-6012D	17. INFORMANT'S SIGNATURE OR NAME Mrs H.A. Reed	ADDRESS 6807 Elmorte Johnson Co. Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Undetermined		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7955
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
		DUE TO (b) _____		
		DUE TO (c) _____		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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. 20, 1953, to Dec. 2, 1953, that I last saw the deceased alive on Dec. 2, 1953, and that death occurred at 10:15 Am., from the causes and on the date stated above.

23a. SIGNATURE H. I. Burns (Degree or title) H. I. Burns M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 12-2-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4 Dec 53	24c. NAME OF CEMETERY OR CREMATORY Floral Hills	24d. LOCATION (City, town, or county) (State) Kansas City Jackson Mo.
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DATE REC'D BY LOCAL REG. 12-3-53	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Floral Hills Mem. Ch. Kansas City, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. O'Blair

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 *A. Ross Blanford*

Licensed Embalmer No. *40131*

P. O. Address *KC 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.