

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 20705
Registrar's No. 4409

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 20705		Registrar's No. 4409	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. _____ b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (In this place) 0		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke's Hospital				e. STREET ADDRESS (If rural, give location) 14 6203 Nottingham Ave.					
3. NAME OF DECEASED (Type or Print) AMELIA			a. (First)		b. (Middle) JACOBSON		c. (Last)		
4. DATE OF DEATH (Month) (Day) (Year) May 17 1954			5. SEX Female			6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH March 30, 1876			9. AGE (In years last birthday) 78		10. UNDER 1 YEAR Months _____		11. UNDER 1 HR. Hours _____		12. UNDER 1 MIN. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Clay Center, Kansas			12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Carl Widegren			13b. MOTHER'S MAIDEN NAME Louise Anderson			14. NAME OF HUSBAND OR WIFE J. A. Jacobson			
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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS J. A. Jacobson 6203 Nottingham Ave.				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Subarachnoid hemorrhage</i> ANTECEDENT CAUSES <i>Hypertension - heart disease</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>1 year</i>	
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) 443 X					
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 1946, 19, to April 17, 1954, that I last saw the deceased alive on April 19, 1954, and that death occurred at 2:10 A.M., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or Title) <i>Raymond C. Sunderman M.D.</i>				23b. ADDRESS 4945 Harvard Bridge Rd			23c. DATE SIGNED 5/17/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail)		24b. DATE 5-19-1954		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Topeka, Kansas			
DATE REC'D BY LOCAL REG. MAY 17 1954		REGISTRAR'S SIGNATURE <i>J. C. Smith</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.				

(Licensed Embalmer's Statement on Reverse Side)

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

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 *Paul A. Johnson*.....

Licensed Embalmer No. *453*.....

P. O. Address *J. Jones M.*.....

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.