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FILED AUG 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28269
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3742

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, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		d. STREET ADDRESS (If outside, give location) 1101 Woodland	
3. NAME OF DECEASED (Type or print) Infant		4. DATE OF DEATH Month August Day 3 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 12
11. BIRTHPLACE (City and state or country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME Herman Jacobs		13b. MOTHER'S MAIDEN NAME Lucy Horton	
14. NAME OF HUSBAND OR WIFE —		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Lucy Jacobs, mother Address 1101 Woodland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from <u>8-3-57</u> to <u>8-3-57</u> and last saw her/him alive on <u>8-3-57</u> Death occurred at <u>1:50 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. R. Peterson M.D. (Degree or title)		22b. ADDRESS 600 E. 22nd Street	22c. DATE SIGNED 8-7-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-22-57	23c. NAME OF CEMETERY OR CREMATORY Fields	23d. LOCATION (City, town, or county) (State) Kansas City MO
24. FUNERAL DIRECTOR Tom Schmyr ADDRESS 150 MO	25. DATE RECD. BY LOCAL REG. 8-10-57	26. REGISTRAR'S SIGNATURE Neva Marshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
W. R. Peterson

(Licensed Embalmer's Statement on Reverse Side)

