

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 Albert Preston, Jr.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

31952

STATE FILE NUMBER 4440

FILED OCT 9 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Neurological Hosp.</i>			Length of stay in hb <i>54 yrs.</i>		d. STREET ADDRESS <i>4801 Roanoke</i> (If outside, give location) Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Rachel</i> Middle Last <i>Jacobson</i>			4. DATE OF DEATH Month <i>Sept.</i> Day <i>23</i> Year <i>1957</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 30, 1881</i>	9. AGE (In years last birthday) <i>77</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (City and state or country) <i>Olney, Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Freidman</i>			14. MOTHER'S MAIDEN NAME <i>Nettle Levi</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Jerome L. Jacobson</i> Address <i>217 W. 51st Ter</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Vascular Accident</i> DUE TO (b) <i>Chronic Brain Syndrome</i> DUE TO (c) <i>arteriosclerosis of brain</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i> <i>2 yrs</i> <i>33 1/2</i>
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 <i>9-14-57</i> to <i>9-23-57</i> and last saw her <sup>her</sup> <sub>him</sub> alive on <i>9-22-57</i> <input checked="" type="checkbox"/> Death occurred at <i>125</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Albert Preston, Jr. M.D.</i> (Degree or title)		22b. ADDRESS <i>4635 Wyandotte</i>		22c. DATE SIGNED <i>9-24-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>9/24/57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City Mo.</i>
24. FUNERAL DIRECTOR <i>J.P. Louis Funeral Home</i> ADDRESS <i>K.C., Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>9-24-57</i>	26. REGISTRAR'S SIGNATURE <i>neva minshall</i>		



1-2-3-4-5

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 *Wm. Buffington*

Licensed Embalmer No. 27

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

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.