

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036903

STATE FILE NUMBER

41

FILED OCT 21 1958

Registration District No. 159 Primary Registration District No. 4249 Registrar's No.

4

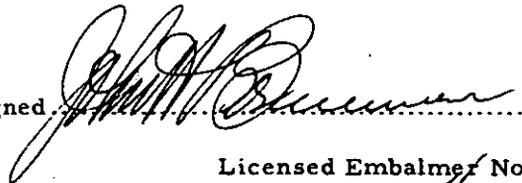
1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jeff.</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>Hillsboro Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>EUREKA Mo RR</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CEAR GROVE HOME</u>			Length of stay in lb <u>6 mos</u>	d. STREET ADDRESS (If outside, give location) <u>Byrnesville Rd</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>VIRGINIA</u> Last <u>JACOBS</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 13-1901</u>		9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public schools</u>		11. BIRTHPLACE (City and state or country) <u>House Springs Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRED JACOBS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE TROWER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>MARY JACOBS Eureka Mo RR</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) _____ DUE TO (c) <u>309 X</u>	
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 type="checkbox"/> NO <input checked="" 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 _____ 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>April 2, 1958</u> , to <u>Oct. 19, 1958</u> and last saw her alive on <u>10-19-58</u> Death occurred at <u>1 P. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert J. Sanders, M.D.</u>				22b. ADDRESS <u>1502 Cass St. Johnia</u>		22c. DATE SIGNED <u>10-19-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/22/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEAR HILL BAP Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>CEAR HILL Mo</u>			
24. FUNERAL DIRECTOR <u>Bremmer Funeral Home House Springs Mo</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-20-58</u>	26. REGISTRAR'S SIGNATURE <u>Oleta Bernardine Sep</u>	

DATE RECEIVED  
OCT 30 1958

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 

Licensed Embalmer No. 11

P. O. Address *House*

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.