

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011044

STATE FILE NUMBER

17 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

2 2240

300  
1-57  
25

797

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp.</u>		Length of stay in lb <u>4 days</u>	d. STREET ADDRESS (If outside, give location) <u>4174 N. Euclid</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>A.</u> Last <u>JACOBS</u>			4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1959</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1895</u>
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u>23</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Optician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Optical Co.</u>	11. BIRTHPLACE (City and state or country) <u>Effingham, Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Frank Jacobs</u>	
13b. MOTHER'S MAIDEN NAME <u>Laura Lawrence</u>		14. NAME OF HUSBAND OR WIFE <u>Johanna Karl Jacobs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>488-09-8882</u>	17. INFORMANT Address <u>Mrs. Johanna Jacobs 4174 N. Euclid</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>acute Left Ventricular failure</u> DUE TO (b) <u>arterio sclerotic Heart</u> DUE TO (c) <u>ischemic process</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>yes</u>
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 <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>1944</u> to <u>Mar. 3-59</u> and last saw him alive on <u>3/3/59</u> Death occurred at <u>3:55 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Chas Miller M.D.</u> (Degree or title)		22b. ADDRESS <u>408 Humbert</u>	
22c. DATE SIGNED <u>Mar 3</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Mar 6 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Celvary Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Bromschwig and Son/w Florissant</u>		ADDRESS <u>4748</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 4 '59</u>
26. REGISTRY'S SIGNATURE <u>Karl Smith. M.D.</u>			

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 .....  
*John J. Thomas*

Licensed Embalmer No. *4108*  
P. O. Address *J. Thomas*

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.