

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

59-012271
STATE FILE NUMBER
28

APR 28 1959 Registration District No. 032 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY BOLLINGER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott	
b. CITY OR TOWN Lutesville Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN LLMO. 1000 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bone Nursing Home Length of stay in lb 5 1/2 yr.		d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED First Middle Last
Margaret MAY Jacobs.

4. DATE OF DEATH Month Day Year
April 10 - 1959

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH **MAY 15 - 1887** 9. AGE (In years) **85** (In years Under 1 year If under 1 year: Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **House wife** 10b. KIND OF BUSINESS OR INDUSTRY **—** 11. BIRTHPLACE (City and state or country) **SPARTA ILL.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **W^m SKELLY** 13b. MOTHER'S MAIDEN NAME **PARNELIA LIVELY** 14. NAME OF HUSBAND OR WIFE **W^m N.B. Jacobs.**

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. **None.** 17. INFORMANT **Mrs. J.W. Johnson, Murphysboro Ill.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Uremia**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **Cardiovascular disease**
DUE TO (c) **—**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **4231**

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 **4-2-54** to **4-10-59** and last saw her alive on **4-10-59**
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **John J. Meyer D.O.** 22b. ADDRESS **Lutesville Mo.** 22c. DATE SIGNED **4-12-59**

23a. BURIAL, CREMATION REMOVALS (Specify) **Burial** 23b. DATE **4-12-59** 23c. NAME OF CEMETERY OR CREMATORY **Caldonia** 23d. LOCATION (City, town, or county) (State) **Sparta Ill.**

24. FUNERAL DIRECTOR ADDRESS **Bushnaghauff Funeral Home** 25. DATE RECD. BY LOCAL REG. **4-21-59** 26. REGISTRAR'S SIGNATURE **Mrs. Buford Oraker**

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

vector, carrier, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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1-57

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 *Olevis C. Amick*

Licensed Embalmer No. *4490*
P. O. Address *Illmo*

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.