

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013359

STATE FILE NUMBER

FILED MAY 1 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1874

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-57

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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) KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RONNOKE NURSING HOME		Length of stay in 1b 53 Yrs	d. STREET ADDRESS (If outside, give location) 424 7 HARRISON ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CONRAD ANTON JACOBSON			4. DATE OF DEATH Month Day Year APRIL 13 1959		
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5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 22-1878	9. AGE (In years of birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR WORKER	10b. KIND OF BUSINESS OR INDUSTRY JOHNSON MFG CO.	11. BIRTHPLACE (City and state or country) Sweden	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME JACOB JACOBSON	13b. MOTHER'S MAIDEN NAME MARIA BOTALFSON	14. NAME OF HUSBAND OR WIFE HURDA O. JACOBSON
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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 MARTIN C. JACOBSON	Address 3930 TROOST K.C. Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Repeated myocardial infarctions (4)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Years.
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Coronary thrombosis	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
	DUE TO (c) General, Coronary & Cerebral Arteriosclerosis 6 Years	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

1) Hypertensive Cardiovascular disease
2) Rt. Hemiplegia due to cerebral thrombosis
3) Prostatic Hypertrophy

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, item 18.) 42c1 obstruction.
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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
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21. I attended the deceased from 1952 to 13 April 59 and last saw him alive on 10 April 1959 Death occurred at 3:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Deceased or title) Philip G. Kaul MD	22b. ADDRESS 411 Nichols Rd.	22c. DATE SIGNED 12 April 59
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23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	23b. DATE April 15-1959	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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24. FUNERAL DIRECTOR Gates	ADDRESS 1901 Olathe Blvd. KANSAS CITY 3, KANSAS	25. DATE RECD. BY LOCAL REG. 4-14-59	26. REGISTRAR'S SIGNATURE Irene Marshall
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Philip G. Kaul

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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 *Paul R. Williams*

Licensed Embalmer No. *5009*

P. O. Address. *Overland, Kan*

Kansas

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.

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