

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013697

STATE FILE NUMBER

FILED APR 30 1959

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 103

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before a. STATE Missouri b. COUNTY Jackson)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Jackson Co. Hosp.		Length of stay in lb 14 mo.	d. STREET ADDRESS 8913 Smart
3. NAME OF DECEASED (Type or print) First Anna Middle Elizabeth Last Jacobson		4. DATE OF DEATH Month April Day 21 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885 Aug. 17, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Wighton, Kansas
13a. FATHER'S NAME Christian Sievers		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE James H. Jacobson
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.	17. INFORMANT Mrs. Alvin Zimmerman
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial insufficiency			
DUE TO (c) Arteriosclerotic heart disease			
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 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 2-11-58 to 4-21-59 and last saw her/him alive on 4-21-59			
Death occurred at 8:30 p. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) A. Sheahan, M.D.		22b. ADDRESS Raytown, Mo.	22c. DATE SIGNED 4-22-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	4-22-1959	Mt. Washington Cem.	Kansas City, Mo.
24. FUNERAL DIRECTOR C. H. Blackman		25. DATE RECD. BY LOCAL REG. 4-23-1959	26. REGISTRAR'S SIGNATURE N. B. Longford

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 5 1959

MAY 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 *W.C. Rine*

Licensed Embalmer No. *4829*.....

P. O. Address *I.C. Md.*.....

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.