

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015176

STATE FILING NUMBER 2 3879

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED MAY 8 1959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	a. STATE Missouri b. COUNTY St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Length of stay in 1b 3 hrs.	d. STREET ADDRESS (If outside, give location) 4341 Melba
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First KENNETH	Middle B.	Last JACOBSMEYER	4. DATE OF DEATH	Month April	Day 19	Year 1959
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5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30 1955	9. AGE (In years last birthday) 3	10. MONTHS 3	11. DAYS 21	12. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Bernard J. Jacobsmeyer	13b. MOTHER'S MAIDEN NAME Ann J. Reiter	14. NAME OF HUSBAND OR WIFE child
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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 Bernard J. Jacobsmeyer	Address 4341 Melba
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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) Uremic Coma		INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Congenital rudimentary R+ kidney and	} 3 1/2 yrs.
	DUE TO (c) Mal development + insufficiency of left kidney	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mal retention and faulty osseous development - Panniculitis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.) 757.3
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from Dec 30 1955 to Apr 19 1959 and last saw him alive on Apr 19 1959 Death occurred at 12:30 am. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE St. C. A. Linsman M.D.	(Degree or title)	22b. ADDRESS 4126 Shrew Ave	22c. DATE SIGNED 4/20/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Apr. 21 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR Bromschwig and Son	ADDRESS W Florissant	25. DATE RECD. BY LOCAL REG. APR 20 '59	26. REGISTRAR'S SIGNATURE Neal Smith, M.D. Sp.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms which are not mentioned in the instructions should be included.

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 *Stanley H. Dixon*
Licensed Embalmer No. *4199*
P. O. Address *S. J.*

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.