

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023028

FILED JUL 2 1959 Registration District No. Primary Registration District No. STATE FILE NUMBER 5930

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis Mo</i>		Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Incarnate Word Hosp</i>		Length of stay in [b] <i>5 days</i>	d. STREET ADDRESS (If outside, give location) <i>3612 Connecticut</i>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Emily</i> Middle <i>Jacoby</i> Last			4. DATE OF DEATH Month <i>6</i> Day <i>20</i> Year <i>1959</i>	
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5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/7/1881</i>	9. AGE (In years last birthday) <i>77</i>	IF UNDER 1 YEAR Months <i>11</i> Days	IF UNDER 24 HRS Hours <i>11</i> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>self</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>St. Louis Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Herman Jacoby</i>	13b. MOTHER'S MAIDEN NAME <i>Jennie Buder</i>	14. NAME OF HUSBAND OR WIFE
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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) <i>no</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. D. [unclear]</i> Address <i>7271 Arlington</i>
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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) <i>intra cerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6/15 to 6/20</i>
DUE TO (b) <i>subacute hemorrhage due to cerebral vascular arteriosclerosis</i>		
DUE TO (c) <i>Arteriosclerotic arteriosclerosis</i>		
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 checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <i>8:30 P</i> a.m. <i>0</i> p.m. <i>0</i>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>6/15</i>	20f. CITY, TOWN, OR LOCATION <i>6/20</i>	COUNTY	STATE
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21. I attended the deceased from Death occurred at <i>6/20 8:30 P</i> and last saw her alive on <i>6/20/59</i> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <i>Ralph Berg MD</i>	22b. ADDRESS <i>32035 Grand</i>	22c. DATE SIGNED <i>6/22/59</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>6/23/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Valhalla</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County Mo.</i>
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24. FUNERAL DIRECTOR ADDRESS <i>Geo. A. Howard 1619 So. Grand</i>	25. DATE RECD. BY LOCAL REG. <i>JUN 23 '59</i>	26. REGISTRAR'S SIGNATURE <i>W. O. Smith M.D. 11/8/59</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *James Dumbly*
Licensed Embalmer No. *3657*
P. O. Address *St. Louis 8 Mo*

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.