

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042026

FILED VS NOV 20 1959

210404

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 mo.	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1111 Wilmington Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Estelle Middle L. Last Jacobs			4. DATE OF DEATH Month 11 Day 10 Year 59				
5. SEX Female	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 1/3/1880	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (City and state or country) DeSoto Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William C. Cosby		13b. MOTHER'S MAIDEN NAME unk.		14. NAME OF HUSBAND OR WIFE Albert F. 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. XXXXXXXXXXXX		17. INFORMANT Address Earle C. Jacobs 1111 Wilmington			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Bulmonary Abscesses (R.L.L.) 2 mos.		INTERVAL BETWEEN ONSET AND DEATH 2 mos.
DUE TO (b) 526x		
DUE TO (c) Bronchiectasis (Etiology Unknown) 2 mos.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rheumatic Heart Disease - 2 mos.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) at time patient was put to bed she	
20c. TIME OF INJURY Hour 9:00 p.m. Month, Day, Year 10/16/59		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St. Louis Chronic Hosp. St. Louis	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St. Louis Chronic Hosp. St. Louis		20f. CITY, TOWN, OR LOCATION St. Louis COUNTY St. Louis STATE Mo.	
21. I attended the deceased from 9-8-59 to 11-10-59 and last saw her/him alive on 11-10-59		Death occurred at 7:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) John W. Beckman, M.D.		22b. ADDRESS 5800 Arsenal		22c. DATE SIGNED 11/10/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Nov, 13 1959		23c. NAME OF CEMETERY OR CEMETERY St. Peters Cemetery	
24. FUNERAL DIRECTOR Beiderwieden F.H.Inc., 1936 St. Louis Ave		25. DATE RECD. BY LOCAL REG. NOV 12 1959		26. REGISTRAR'S SIGNATURE Roal Smith, M.D.	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James P. Lee*

Licensed Embalmer No. 452

P. O. Address St. Louis

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.