

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016104

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 62

AMENDED

FILED APR 24 1961

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Saline</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Marshall</b>                                       |  | Length of stay in 1b<br><b>27 yrs.</b>  | c. CITY OR TOWN <b>Chillicothe</b><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                     |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>Marshall State School &amp; Hospital</b> |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>105 Ninth St.</b><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>Cecil</b> Middle <b>Oliver</b> Last <b>Jacobs</b> |  |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>18</b> Year <b>1961</b> |  |
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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|--|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-12-1925</b> | 9. AGE (last birthday)<br><b>36</b> | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HR<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Patient</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b> | 11. BIRTHPLACE (City and state or country)<br><b>Chillicothe, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
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| 13a. FATHER'S NAME<br><b>Elmer Oscar Jacobs</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Anna May Uhrmather</b> | 14. NAME OF HUSBAND OR WIFE<br><b>----</b> |
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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)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT<br><b>Records of Marshall State School &amp; Hosp., Marshall, Mo.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hydrocephalus -congenital</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Lifetime</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____                               |  |   |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED?<br>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.) |
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| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____ | 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<br>COUNTY _____ STATE _____ |
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| 21. I attended the deceased from <b>4-1-1959</b> to <b>4-18-61</b> and last saw him alive on <b>4-18-61</b><br>Death occurred at <b>11:10 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <b>A. B. Day</b> (Degree or title) <b>M.D.</b> | 22b. ADDRESS<br><b>Marshall State School &amp; Hosp.</b> | 22c. DATE SIGNED<br><b>4-19-61</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>4-19-1961</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Stuckens Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Chillicothe Mo</b> |
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| 24. FUNERAL DIRECTOR<br><b>Harry Hershberger</b> | ADDRESS<br><b>Marshall Mo</b> | 25. DATE RECD. BY LOCAL REG.<br><b>4-19-61</b> | 26. REGISTRAR'S SIGNATURE<br><b>Cecil H. Read</b> |
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DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall 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.