

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037688

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9799** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED OCT 10 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 mos.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1808a Cora Ave.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) PRINCE ALBERT JACOBS						4. DATE OF DEATH Sept. 29, 1963		5. SEX Male		6. COLOR OR RACE Negro					
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11/11/21		9. AGE (last birthday) 41		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY Interior Decorator					
11. BIRTHPLACE (City and state or country) Nacogdoches, Texas				12. CITIZEN OF WHAT COUNTRY USA				13a. FATHER'S NAME Charlie Jacobs		13b. MOTHER'S MAIDEN NAME Eva Johnson		14. NAME OF HUSBAND OR WIFE -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) None				16. SOCIAL SECURITY NO. [Redacted]		17. INFORMANT Hospital Records				Address		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: i. IMMEDIATE CAUSE (a) Recurrent intracerebral tumor (Astrocytoma) DUE TO (b) Pulmonary and circulatory insufficiency DUE TO (c) 193.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 a.m. p.m.		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		COUNTY		STATE			
21. I attended the deceased from May 1, 1963 to Sept. 29, 1963 and last saw ^{him} alive on Sept. 29, 1963 Death occurred at 3:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <i>[Signature]</i>						22b. ADDRESS 5100 Arsenal St.			22c. DATE SIGNED 9/30/63						
23a. BURIAL, CREMATION, REMOVAL (Specify) shipped				23b. DATE 10/3/1963		23c. NAME OF CEMETERY OR CREMATORY Nacogdoches, Texas		23d. LOCATION (City, town, or county) (State)							
24. FUNERAL DIRECTOR Metropolitan Funeral System, Inc.				ADDRESS 5010 Enright		25. DATE RECD. BY LOCAL REG. OCT 2 1963		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

USE BLACK INK OR TYPEWRITER RIBBON

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

John K. Cunningham

Licensed Embalmer No. 14476

P. O. Address 2405 Marcus

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.

8-1-01