

S. No. 2  
1-8-43  
5-17-39  
PI X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11282

FILED JAN 12 1945

Registration District No. 137

Primary Registration District No. 4214

State File No. ....

Registrar's No. 214

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Deepwater Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry 4.2  
(c) City or town Deepwater Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ethel May Jacoby  
(b) If veteran, name war No  
(c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 6th 1944  
year 1944 hour 11 P.M. minute \_\_\_\_\_ M. \_\_\_\_\_  
21. I hereby certify that I attended the deceased from Feb 10, 1944, to Dec 6, 1944  
that I last saw her alive on Dec 5, 1944  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (c) Age of husband or wife if alive 53 years  
7. Birth date of deceased: August 8 1991  
(Month) (Day) (Year)

Immediate cause of death  
Chronic Myocarditis, Intubation Blue  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 53 Months 3 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death) 93d  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Smith Center Kansas  
(City, town, or county) (State or foreign country)  
10. Usual occupation House Keeper

11. Industry or business \_\_\_\_\_  
12. Name Clarence Welch  
13. Birthplace Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Hawkins  
15. Birthplace Iowa  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Wayne Jacoby  
(b) Address Deepwater Mo  
17. (a) Burial (b) Date thereof 12-9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Deepwater Mo  
18. (c) Signature of funeral director Tom Hunt  
(b) Address Deepwater Mo  
19. (a) December 8 1944 Georgia Kitchen  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature J. Russell (M. D. or other) \_\_\_\_\_  
Address Deepwater Date signed 12/7/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

200

RECEIVED

District Health Officer No. 7,

District File Number 12-44-1470

Date Filed 1-9-45

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Jam Smith

Licensed Embalmer No. 2282

P. O. Address Depue, 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 this body is not embalmed, fact should be so stated above.**