

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013073

STATE FILE NUMBER

8

FILED MAY 11 1959

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 113

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|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HENRY</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>HENRY</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>CLINTON</b>             |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>URich</b> 0420<br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                             |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTE <b>WETZEL HOSP</b> |  | Length of stay in 1b<br><b>2 days</b>  | d. STREET ADDRESS (If outside, give location)<br><b>NONE</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MARGIE LEE JACOBS</b> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>MAY 3 1959</b> |  |  |  |
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| 5. SEX<br><b>FEMALE</b> | 6. COLOR, OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 28 1911</b> | 9. AGE (In years last birthday)<br><b>47</b> | IF UNDER 1 YEAR<br>Months Days<br><b>10 3</b> | IF UNDER 24 HRS.<br>Hours Min.<br><b>- -</b> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b> | 11. BIRTHPLACE (City and state or country)<br><b>SRAIS COUNTY OKLA</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
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| 13a. FATHER'S NAME<br><b>JOHN T YEATES</b> | 13b. MOTHER'S MAIDEN NAME<br><b>ANNA S BRAUNGARDT</b> | 14. NAME OF HUSBAND OR WIFE<br><b>ORVA JACOBS</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>NO</b> | 17. INFORMANT<br><b>ORVA JACOBS URICH MO</b> |
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| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b>                                    |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>HRS</b>                       |
| DUE TO (b) <b>Circulatory Failure</b>   |  |  |
| DUE TO (c) <b>Embolism</b>  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Congenital Atrioventricular Septal Defect</b> |  | 19. WAS AUTOPSY PERFORMED?<br><b>YES</b> NO <input type="checkbox"/> |

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| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year<br>a.m. p.m. | 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 |
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| 21. I attended the deceased from<br>Death occurred at <b>9:30 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated. | 21. I attended the deceased from <b>Dec. 1957</b> to <b>MAY 3rd</b> and last saw her alive on <b>May 3rd</b> |
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| 22a. SIGNATURE (Degree or title)<br><b>Arturo Gonzalez DO</b> | 22b. ADDRESS<br><b>2 717 E Jefferson Clinton</b> | 22c. DATE SIGNED<br><b>5-3-59</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 23b. DATE<br><b>May 5, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MULLENS</b> | 23d. LOCATION (City, town, or county) (State)<br><b>URICH MO</b> |
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| 24. FUNERAL DIRECTOR<br><b>Schaberg Funeral Home</b> | ADDRESS<br><b>Clinton MO</b> | 25. DATE RECD. BY LOCAL REG.<br><b>5-5-59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Mildred Bigum</b> |
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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 F. L. Schaberg

Licensed Embalmer No. 4513  
P. O. Address Clinton, 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.