

Registration District No. 391

Primary Registration District No. 4230

Registrar's No. 54

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson  
(c) City or town Old Mines  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Jacob M. Palitte  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 10 - 1948  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 9 15 hr. \_\_\_\_\_ min.

9. Birthplace Old Mines (City, town, or county) MO (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Fred Palitte  
13. Birthplace Jacobs (City, town, or county) MO (State or foreign country)  
14. Maiden name Agat Runde  
15. Birthplace Broomfield (City, town, or county) MO (State or foreign country)

16. (a) Informant Fred Palitte  
(b) Address address

17. (a) \_\_\_\_\_ (b) Date thereof Aug 26 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation old mines

18. (a) Signature of funeral director Harbo

(b) Address Palitte

19. (a) Aug - 25 - 40 (Date received local registrar) Julia A. Newton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25  
year 1940 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug. 23, 1940, to Aug 25, 1940;  
that I last saw him alive on Aug 24, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bacillary Dysentery  
Duration 10 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Mongolism  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 Ben W. Bull (M. D. or other) M. D.  
Address Fronton, Mo. Date signed 8-25-40

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

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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, above space should be left blank.**