

Registration District No. 1095Primary Registration District No. 4336

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Moniteau
(b) City or town Clarksburg
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life (Specify whether)
years, months or days 23. (a) PRINT FULL NAME Rachel A. Cobb3. (b) If veteran, name war no 3. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife Rufus Cobb 6. (c) Age of husband or wife if alive Dead years7. Birth date of deceased July 24th, 1855
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
85 3 24 hr. _____ min.9. Birthplace Virginia
(City, town, or county) (State or foreign country)10. Usual occupation At home /11. Industry or business --12. Name George Albin /13. Birthplace Virginia
(City, town, or county) (State or foreign country)14. Maiden name Mary A. Smith15. Birthplace Unknown /
(City, town, or county) (State or foreign country)16. (a) Informant J. E. Cobb(b) Address Lepton Mo. Rt # 117. (a) Burial (b) Date thereof 11/19/40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Moreau Cemetery18. (a) Signature of funeral director James E. Richards(b) Address Lepton Mo19. (a) 11-20-40 (b) J. C. Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Moniteau
City or town Clarksburg
(If outside city or town limits, write "RURAL")(d) Street 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 18th.
year 1940 hour 5 minute 10 A.M.21. I hereby certify that I attended the deceased from Nov. 3
1940, to Nov. 16, 1940
that I last saw her alive on Nov. 16, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Hydrostatic Pneumonia /
Duration 10/14/40

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

741 _____ (Specify type of place)
While at work _____ (e) Means of injury _____23. Signature H. D. Danion (M.D. or other) MDAddress California Mo Date signed _____

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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 Me

Registered Apprentice No. _____

working under my personal supervision.

Signed James E. Richards
Licensed Embalmer No. 2466
P. O. Address Lipton, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39258

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1095-

Primary Registration District No. 4336

Registrar's No. _____

WILKIN MOORE

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

1. PLACE OF DEATH:
 (a) County Moniteau
 (b) City or town Charlestown
 (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)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Rachel a Cobb
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
 7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 85 Months 3 Days 24 If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
 { 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 { 14. Maiden name _____
 { 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (Specify type of place)
 (b) Address _____ (2) Means of injury _____

19. (a) _____ (b) _____ (Registrar's signature)
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Moniteau
 (c) City or town Charlestown (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 11 day 18
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
 that I last saw h. _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
 Due to Bronchial pneumonia 7 days
 Due to _____

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

Major findings: 107W
 Of operations _____
 Of autopsy _____

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

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)
 (2) Means of injury _____
 23. Signature H. D. Bonior (M.D. or other) D. O.
 Address California, Mo Date signed 11/31/41

SUPPLEMENTARY

S-39258

1940