

FILED JUN 11 1941

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
 (b) City or town Rural, Seneca Twp.
 (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 _____
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Newton
 (c) City or town Rural, Newsho R.D. #4
 (d) Street No. _____
 (e) Citizen of foreign country? _____
 If yes, name country _____

3. (a) PRINT FULL NAME

Eva Cobb

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb. 8 1899
 (Month) (Day) (Year)

8. AGE: Years 52 Months 3 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Keeper

11. Industry or business _____

12. Name Joseph Sanders

13. Birthplace Indiana
 (City, town, or county) (State or foreign country)

14. Maiden name Martha Francisco

15. Birthplace Ark.
 (City, town, or county) (State or foreign country)

16. (a) Informant Ruby Myllins

(b) Address Newsho, Rt. 4

17. (a) Burial (b) Date thereof 5/17/41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Opusless Cemetery

18. (a) Signature of funeral director Chas. W. Williams

(b) Address Goodman Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
 year 1941 hour _____ minute 12 P.M.

21. I hereby certify that I attended the deceased from June 1
 1941 to May 10 1941
 that I last saw him alive on _____ 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of Brain Duration 1 month

Due to Tuberculosis of Lung Duration 5 years

Other conditions (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? _____

(e) While at work? _____ (Specify type of place)

(f) Signature Stella (M.D. or other) _____

(g) Address Stella Mo. Date signed 7/11/41

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 641-915

Date Filed JUN 9 1941

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18552

Registration District No. 611

Primary Registration District No. 5812

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Seneca Twp.
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Eva Coff
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 22 Months 3 Days 7 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8/9/44 (b) Mrs. Spahr
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1944 hour _____ minute _____ M.

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

Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. Cardwell (M. D. or other) _____

Address Stella no Date signed _____

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

SUPPLEMENTARY

S-18552-1941