

No. 2  
1-4-41  
17-39  
X28390

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS  
FILED NOV 14 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

36319  
State File No. ....

Registration District No. 836

Primary Registration District No. 6098A

Registrar's No. 5-3

1. PLACE OF DEATH:  
(a) County Stoddard  
(b) City or town Bernie Rural  
(c) Name of hospital or institution: Home  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community Life

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Stoddard  
(c) City or town Bernie "Rural"  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 31  
year 1941 hour 11 minute P. M.  
21. I hereby certify that I attended the deceased from 4-25-1940  
1940 to 10-31-1941  
that I last saw him alive on 10-31-1941  
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. (b) Name of husband or wife Geo. Mobley  
6. (c) Age of husband or wife if alive 60  
7. Birth date of deceased Sep-16-1887

Immediate cause of death Tuberculosis of the lungs  
Duration 18 months

8. AGE: Years 54 Months 1 Days 15  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Expans & Inheratance  
Due to \_\_\_\_\_

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

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Mats Scales  
13. Birthplace IND  
14. Maiden name White  
15. Birthplace Mo.

PHYSICIAN  
Underline the cause to which death should be charged statistically. 138

16. (a) Informant Husband Geo. Mobley  
(b) Address Bernie, Mo.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(c) Place: burial or cremation Bethany

(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director Landon James  
(b) Address Campbell, Mo.

(e) Means of injury \_\_\_\_\_  
While at work \_\_\_\_\_

19. (a) 11-3-41 (b) Laura Hopkins  
(Date received local registrar) (Registrar's signature)

23. Signature Harvey Ryan (M.D. or other) \_\_\_\_\_  
Address Bernie Mo Date signed 11-1-41

0703 (Licensed Embalmer's Statement on Reverse Side)

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

3  
0  
0

RECEIVED

District Health Office No. 2,

District File Number 1141-1532

Date Filed 11/12/41

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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.....

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

*Embalming  
Nov.*

Signed W. Embalming

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.