DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13921

FILED MAY 21 1942

Registration District No. 1208 — Primary Registration District No. 3009 — Registrar's No. 114

1. PLACE OF DEATH:

(a) County: Cape Girardeau

(b) City or town: Cape Girardeau C. T.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 723 N. Henderson
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 5 months

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: [illegible]

(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 9
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME: IRA - McCombs

3. (b) If veteran, name war: ____

3. (c) Social Security No. 491-16-6383A

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Hettie Jane McCombs

6. (c) Age of husband or wife if alive: Late years

7. Birth date of deceased: Sept. (Month) 4 (Day) 1871 (Year)

8. AGE: Years 70 | Months 7 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace: Longtown (City, town, or county) Ohio (State or foreign country)

10. Usual occupation: Parcel Post Department

11. Industry or business: Clerk

MOTHER FATHER

12. Name: Robert B. McCombs

13. Birthplace: Perry (City, town, or county) Ohio (State or foreign country)

14. Maiden name: Sophronia Abernathy

15. Birthplace: Perry (City, town, or county) Ohio (State or foreign country)

16. (a) Informant's own signature: R. H. Malone

(b) Address: 723 N. Henderson Cape Girardeau Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-15-42 (Month) (Day) (Year)

(c) Place: burial or cremation: York Chapel

18. (a) Signature of funeral director: Wilson-Stalls-Seabaugh

(b) Address: Jackson Mo.

19. (a) 4-14-42 (Date received local registrar) (b) F. V. Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 13 year 1942 hour 1 minute 45 P M.

21. I hereby certify that I attended the deceased from Mar 7, 1942, to Apr 13, 1942, that I last saw him alive on Apr 13, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hours
Due to Arterio-Sclerosis	4 years
Due to Do not Know	
Other conditions (Include pregnancy within 3 months of death): intestinal Obstruction	2 days

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: Carl H. Zimmermann (M. D. or other)

Address: Cape Girardeau Date signed: Apr 14, 42

1114 (Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 — 1 X19511

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

RECEIVED

District Death Officer No. 4

District File No. 542 - 679

Date Filed 5-19-42

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.

V. S. No. 2B
9M—8-21-41
I X29288

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STANDARD CERTIFICATE OF DEATH

State File No. 13921

Registration District No. ..... Primary Registration District No. 3009 Registrar's No. .....

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

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau
(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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: —
(c) City or town: St Louis
(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 .....

3. (a) PRINT FULL NAME: Ira - McCombs
3. (b) If veteran, name war .....
3. (c) Social Security No. 491-16-6385
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Sept - 4 - 1871 (Month) (Day) (Year)
8. AGE: Years 70 Months 7 Days ..... (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)
MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 13 Year 1942 Hour ..... Minute 45 P.M.
21. I hereby certify that I attended the deceased from ..... 19..., 19...; that I last saw him alive on ..... 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Arteriosclerosis	
Due to:	
Due to: Suspect malignancy but could not prove it	
Other conditions (Include pregnancy within 3 months of death): Intestinal obstruction	

Major findings:
Of operations .....
Of autopsy: 122 f 2

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature: Carl [illegible] (M. D. or other)
Address ..... Date signed .....

SUPPLEMENTARY