

DEPARTMENT OF COMMERCE
Bureau of Vital Statistics
FILED AUG 10 1945 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Warrensburg Hospital & Clinic, Inc.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 32 days (Specify whether
In this community 32 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Higginsville, (Rural)
(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 Iva Grace Cobb

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

4. Sex 1 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Edward Cobb 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Sept 19 1902 (Month) (Day) (Year)

8. AGE: Years 42 Months 9 Days 27 If less than one day hr. _____ min _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name A. L. Shope
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name Jessie Dunslop
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Edward Cobb
(b) Address Higginsville Mo
17. (a) not taken (b) Date thereof July 17 1945 (Month) (Day) (Year)
(c) Place: burial or cremation none taken

18. (a) Signature of funeral director Asst. Dir.
(b) Address Higginsville Mo
19. (a) July 17 1945 (Date received local registrar) (b) Leola M. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1945 hour 10 minute P M.
21. I hereby certify that I attended the deceased from July 16 1945 to July 16 1945
that I last saw her alive on 7-16-45 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Breast Duration 6 mo

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

Major findings: Of operations 50 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 P. F. M. Williams (M. D. or other) MD
Address Warrensburg Mo Date signed 7-17-45

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

FEB 27 1943

FEB 7 1943

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

W. H. Hodie

Licensed Embalmer No.

4469

P. O. Address

Heggenwille and

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.