

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 24 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41333

State File No. _____

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 402

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Harribal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Leveering Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64
(c) City or town Harribal 3
(If outside city or town limits, write "RURAL")
(d) Street No. 309 1/2 W main 4
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Everette L. Gobb

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

4. Sex Male 5. Color or race W.M.T. 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 1, 1884
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____ 9

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

14. Maiden name _____ 7

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

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

17. (a) Removal (b) Date thereof Dec. 28, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jonesboro, Arkansas

18. (a) Signature of funeral director James O. Wainwright
(b) Address Harribal, Mo

19. (a) 12-23-46 (b) W. E. M. Lucke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21 year 1946 hour _____ minute 7 P M.

21. I hereby certify that I attended the deceased from 19 Dec 1946 to 21 Dec 1946
that I last saw him alive on 21 Dec 1946 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Cirrhosis of liver
Due to _____

Other conditions Cardiac decompensation
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 124 B

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 0

23. Signature W. J. Pallen (M. D. or other) _____
Address 113a S. Main Date signed 23 Dec 46

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

MOTHER FATHER

189

(Licensed Embalmer's Statement on Reverse Side) Harribal, Mo

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..... *H. M. O'Connell*

Licensed Embalmer No..... *3889*

P. O. Address..... *Hennepin MN*

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.