

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3838

State File No.

FILED MAR 10 1952

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>84</u>		
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KIRKSVILLE</u>		c. LENGTH OF STAY (in this place) <u>YRS.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KIRKSVILLE</u>		<u>0013</u>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Grim Smith Hos.</u>				d. STREET ADDRESS (If rural, give location) <u>505 S. Ekson</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>SUSIE</u>			b. (Middle) <u>Hobbie</u>		c. (Last) <u>Hobbie</u>			
4. DATE OF DEATH		Month (Day) (Year) <u>MAR 4, 1952</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Jan 2, 1876</u>		
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 Hrs. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>		11. BIRTHPLACE (State or foreign country) <u>MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Charles H. Wallace</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Martin</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. Hobbie (D)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Wallace Hobbie, Fayetteville, N.C.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio-Vascular - Renal Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>442X</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>Feb 27, 1952</u> , to <u>March 4, 1952</u> , that I last saw the deceased alive on <u>March 4, 1952</u> , and that death occurred at <u>9:29 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>H. R. Hudson M.D.</u> (Degree or title)				23b. ADDRESS <u>Kirkville, Mo.</u>		23c. DATE SIGNED <u>3-4-52</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3/6/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND PARK</u>		24d. LOCATION (City, town, or county) (State) <u>KIRKSVILLE, MO.</u>		
DATE REC'D BY LOCAL REG. <u>3-5-52</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Davis</u>		ADDRESS <u>Kirkville, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Litkerville, 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, fact should be so stated above.