

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024471
STATE FILE NUMBER

FILED AUG 7 1958 Registration District No. _____ Primary Registration District No. 4009 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY ANDREW		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ANDREW	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SAVANNAH		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SAVANNAH 0020
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 710 WEST DAVIS		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 710 WEST DAVIS
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last MINNIE GRACE Cobb			4. DATE OF DEATH Month Day Year JULY 23 1958		
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 1, 1888	9. AGE (In years last birthday) 70	FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) ANDREW CO., MO.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John R. Bowman	13b. MOTHER'S MAIDEN NAME MARY ANN Shaffer	14. NAME OF HUSBAND OR WIFE EMMETT F. Cobb
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address EMMETT F. Cobb, SAVANNAH, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Accident		INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) A. S. Heart disease	10 yrs	
DUE TO (c) 4200		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Choleliths		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year g.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from **12-8-57** to **7-23-58** and last saw ~~him~~ **her** alive on **7-21-58**
Death occurred at **9:00 A.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or title) William P. Baker M.D.	22b. ADDRESS Savannah, Missouri	22c. DATE SIGNED 7-23-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7-25-58	23c. NAME OF CEMETERY OR CREMATORY SAVANNAH CEMETERY	23d. LOCATION (City, town, or county) (State) SAVANNAH, Mo.
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24. FUNERAL DIRECTOR BREIT FUNERAL HOME, SAVANNAH	ADDRESS	25. DATE RECD. BY LOCAL REG. 7-30-58	26. REGISTRAR'S SIGNATURE Lillian Sparks
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *James B. Hawkins*

Licensed Embalmer No. *4536*

P. O. Address *Lawrence*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.