

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031538
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 119

FILED AUG 26 1958

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Springfield 0390
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Nevada State Hospital #3		Length of stay in lb 6-8-6	d. STREET ADDRESS (If outside, give location) Rt. # 10

3. NAME OF DECEASED (Type or print) First Middle Last Clara Maude Cobb			4. DATE OF DEATH Month Day Year 8-18-1958			
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-1888	9. AGE (In years last birthday) 69	10. FUNDER 1 YEAR Months Days	11. 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) Unknown	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Mas Weber	13b. MOTHER'S MAIDEN NAME Kate Littlemeyer	14. NAME OF HUSBAND OR WIFE James B. Cobb
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Give war or dates of service) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Adm Papers	Address ?
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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) Broncho Pneumonia Coronary Vessel Disease		INTERVAL BETWEEN ONSET AND DEATH 5 days Years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Senil Dementia		Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201		

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.) 4201
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	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 4-25-55 to 8-18-58 and last saw her alive on 8-17-58 Death occurred at 5:40 m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) E. Allertons MD	22b. ADDRESS Nevada, Mo.	22c. DATE SIGNED 8-18-58
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23. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/18/58	23c. NAME OF CEMETERY OR CREMATORY Local.	23d. LOCATION (City, town, or county) (State) Springfield, Mo.
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FUNERAL DIRECTOR Ralph Shemie	ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 8-19-58	26. REGISTRAR'S SIGNATURE Uma E. Ferry
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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.

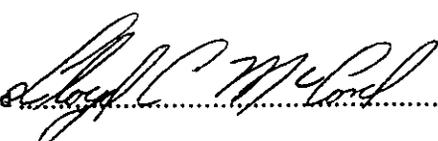
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4853

P. O. Address *Merced, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.