

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005129

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 93A

300
1-57

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SPRINGFIELD</u> ¹³⁹⁶ 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHN'S</u>		Length of stay in lb <u>30 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>2304 S. FREEMONT</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>K.</u> Last <u>DOBBS</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>25</u> Year <u>59</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11, 1877</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ARK.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>W.M. DOBBS</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH CARNAHAN</u>		14. NAME OF HUSBAND OR WIFE <u>ELLA S. DOBBS</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. <u>432-28-850</u>	17. INFORMANT <u>GEO. DOBBS</u>		Address <u>2304 S. FREEMONT</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease</u>	<u>?</u>	
	DUE TO (c) <u>Generalized Arteriosclerosis</u>	<u>3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4260</u>			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.)		
20c. TIME OF INJURY Hour <u>4:45 PM</u> Month, Day, Year					

20d. INJURY OCCURRED WHILE AT WORK <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 <u>Springfield, Mo.</u>	COUNTY	STATE <u>ARK.</u>
21. I attended the deceased from <u>12-25-59</u> to <u>1-25-59</u> and last saw ^{her} him alive on <u>1-25-59</u> Death occurred at <u>4:45 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <u>Harold H. Luise, M.D.</u> (Degree or title)		22b. ADDRESS <u>609 Cherry Springfield, Mo.</u>		22c. DATE SIGNED <u>1-30-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BRUNO</u>		23d. LOCATION (City, town, or county) (State) <u>BRUNO ARK.</u>

24. FUNERAL DIRECTOR <u>HOLT FUNERAL HOME - HARRISON, ARK.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-9-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

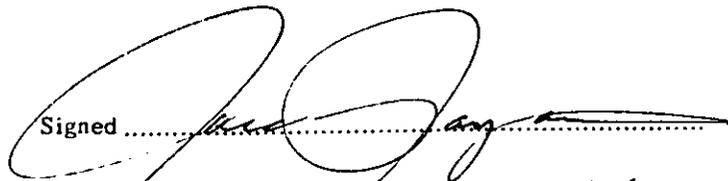
MEDICAL CERTIFICATION

County, coroner, etc., must use only standard nomenclature in their reports. No symptoms will be listed. All diseases in Part I must be causally related.

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. 1061
P. O. Address Hyon Ave

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.