

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039174

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 480 STATE FILE NUMBER

Filed OCT 22 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59	DATE AMENDED	
1 0168		
2 0116		
3		
4 1		
5 7		
6		
7 0		
8 0		
9 331x		
10		
11		
12 30		
13 10		
	INSTEAD OF	
	DOCUMENT	
	MEDICAL CERTIFICATION	
	BY AFFIDAVIT OF	
	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	
	ITEM NO. SHOULD READ	
	SHOULD READ	

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		c. CITY OR TOWN Jackson	
Length of stay in 1b 1 week		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Southeast Hospital		d. STREET ADDRESS (If outside, give location) 234 Elmwood	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE COBBLE		4. DATE OF DEATH October 17, 1963	
First Middle Last		Month Day Year	
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 9/20/1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Millersville, Mo.
13a. FATHER'S NAME Benjamin Howard		13b. MOTHER'S MAIDEN NAME Hattie Miller Howard	
14. NAME OF HUSBAND OR WIFE Guy Cobble		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No U/A	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. J. E. Hagans, Jackson, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) -		DUE TO (c) -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) -		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m.	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 COUNTY STATE
21. I attended the deceased from Dec. 1950 to 10-17-63 and last saw her alive on 10-17-63 Death occurred at 9:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) E. F. McDonald, M.D.		22b. ADDRESS Jackson, Mo.	22c. DATE SIGNED 10-18-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/20/1963	23c. NAME OF CEMETERY OR CREMATORY Russell Heights	23d. LOCATION (City, town, or county) (State) Jackson, Missouri
24. FUNERAL DIRECTOR A. G. Gault ADDRESS Jackson, Mo.		25. DATE RECD. BY LOCAL REG. 10-19-63	26. REGISTRAR'S SIGNATURE Gene Kasten

USE BLACK INK OR TYPEWRITER RIBBON

471000-002

Faint, mostly illegible text at the top of the page, possibly containing a name and address.

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 *[Handwritten Signature]*

Licensed Embalmer No. 4397

P. O. Address *[Handwritten Address]*

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.