NOV 22

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. Shelter

1. PLACE OF DEATH
County: Miller
Township: Franklin
City: (No. ..... St. ..... Ward)
Registration District No.: 27928-a 561
Primary Registration District No.: 5756
File No.: 27928-a
Registered No.: 62

2. FULL NAME: William M. Jobson
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR): 8-14-1857
7. AGE: YEARS 71 MONTHS DAYS 5 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ill.

PARENTS
10. NAME OF FATHER: X X
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): X X
12. MAIDEN NAME OF MOTHER: X X
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): X X

14. INFORMANT: Jas Jobson
(Address): Eldon
15. FILED 11-10 1928 Belle Haynes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug 19 1928
17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1928, to Aug 19, 1928, that I last saw him alive on Aug 18, 1928, and that death occurred, on the date stated above, at 10 P.M.
THE CAUSE OF DEATH* WAS AS FOLLOWS: Cerebral Hemorrhage
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (SECONDARY): Arteriosclerosis
(duration) 3 yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) E C Shelton, M.D
, 19 (Address) Eldon Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Blue Spring
DATE OF BURIAL: 8/20 1928
20. UNDERTAKER: W. C. Phillips
ADDRESS: Eldon, Mo

...information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Miller — Registration District No. 561 — File No.
Township: Franklin — Primary Registration District No. 5-756 — Registered No. 62
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME William M. Gobson

(a) Residence. No. ..... St. ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTY) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTY) Not Known

14. INFORMANT .....
(Address)

15. FILED 11-10, 1928 Belle Haynes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1928

17.
I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
..... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

NOTE B.—Every ... information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that ... classified. Exact statement of OCCUPATION is very important.

... SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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