

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

Do not use this space  
21640

**PLACE OF DEATH**

County Stoddard Co  
Township Richland  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 827  
Primary Registration District No. 6070

File No. 51  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Irma Eschal Hobbs

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) defunct

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12 - 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
7 2 1

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) Stoddard Co Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Illegitimate child

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lucile Hobbs

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Scott Co Mo  
(STATE OR COUNTRY)

14. INFORMANT Anderson Hobbs  
(Address) Stoddard R.F.D. Mo

15. FILED 7/17/30 Walter E. Davis  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 13 - 1930

17. I HEREBY CERTIFY, That I attended deceased from June 9 - 1930 to June 13 - 1930 that I last saw him alive on June 12 - 1930 and that death occurred, on the date stated above, at 8 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Cholera Infantum

CONTRIBUTORY (SECONDARY) 11/30 (duration) yrs. mos. ds.

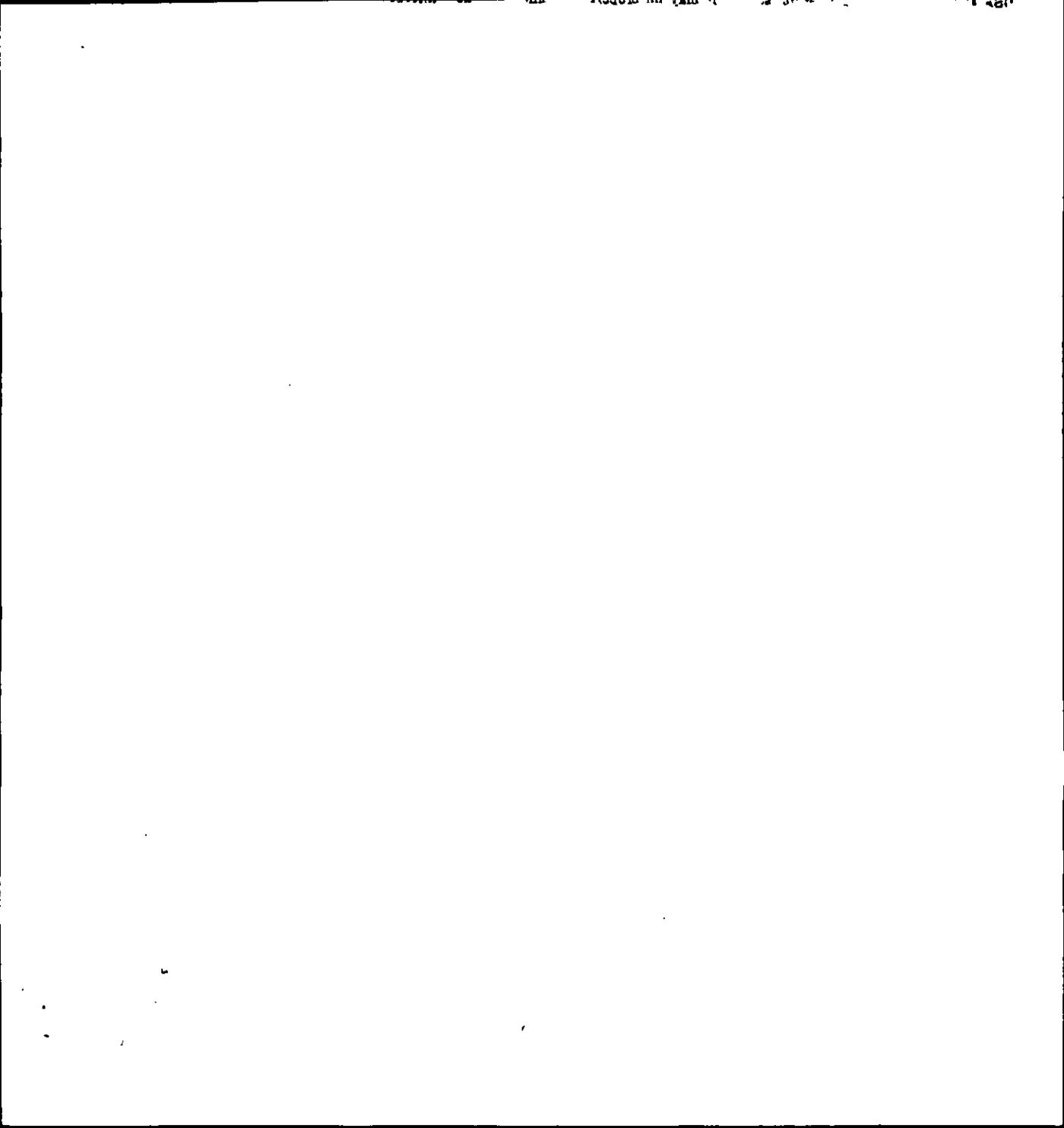
18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) A A Mayfield, M. D.  
June 14, 1930 (Address) Stoddard

\*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 Stoddard DATE OF BURIAL 6/14 1930

20. UNDERTAKER W. J. Clark ADDRESS Stoddard

mo





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