

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

Do not use this space.

39517

1. PLACE OF DEATH U.S.V. Hosp.

County Jackson

Registration District No. _____

Township Law

Primary Registration District No. _____

City Kansas City, Mo.

(No. U.S. Veterans Hosp.)

File No. _____

Registered No. 11090

St. _____ Ward _____

2. FULL NAME COBB, Andy

(a) Residence. No. Bethel, Kansas St. _____

Pvt. Unassg. Last Assg. Co B 7th Inf

(Usual place of abode)

Route 1

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male

White

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 2, 1890

7. AGE

YEARS
40

MONTHS
1

DAYS
16

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Springfield
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____

14. INFORMANT Hospital Records.

(Address) U.S. Veterans Hosp.

15. FILED 12/19, 1930 M.M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 18 1930

17. I HEREBY CERTIFY, That I attended deceased from December 12, 1930, to December 18, 1930 that I last saw him alive on December 18, 1930, and that death occurred, on the date stated above, at 11:50 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia lobar right upper and middle lobes 108

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Phys. Exam & X-ray

Henry A. Stikes, M.D.
U.S.V. Hospital, Kansas City, 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

Highland Park DATE OF BURIAL 12/20 1930

20. UNDERTAKER K.C. Kansas ADDRESS Freeman Mortuary
Kansas City Mo.

Every item of 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.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....