

N. B.—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.

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

Do not use this space.

DEC 19 1935

36604

1. PLACE OF DEATH

County Linn Registration District No. 496  
Township \_\_\_\_\_ Primary Registration District No. 3022  
City Brookfield (No. Brookfield Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 111

2. FULL NAME Faye Evelyn Stobbart

(a) Residence, No. Stobbart Green house, 1st Ward.

(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F.</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Frank Stobbart</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 27th., 1892</u>				
7. AGE	YEARS <u>43</u>	MONTHS <u>4</u>	DAYS <u>2</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>At home</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____			
	10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Fairfax Mo.</u>				
FATHER	13. NAME <u>W. J. Sellers</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>near Fort Wayne, Ind.</u>			
MOTHER	15. MAIDEN NAME <u>Martha Elenor Taylor</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ringold, Iowa</u>			
17. INFORMANT <u>Faye Stobbart</u> (ADDRESS) <u>Brookfield</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Rose Hill</u> DATE <u>Dec. 1st, 1935</u>				
19. UNDERTAKER <u>E. White</u> (ADDRESS) <u>Brookfield</u>				
20. FILED <u>Dec. 9, 1935</u> <u>J. H. Lucas, M.D.</u> Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/29/35, 1935

22. I HEREBY CERTIFY, That I attended deceased from 11-27, 1935, to 11-29, 1935  
I last saw her alive on 11-29, 1935 Death is said to have occurred on the date stated above, at 8:30 P.M.  
The principal cause of death and related causes of importance were as follows:  
Lobar Pneumonia  
108  
Other contributory causes of importance:  
acute Myocarditis  
11-28-35

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis? Usual Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) G. E. Enoch, M.D.  
(Address) Brookfield, Mo.

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