

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

Do not use this space.

1. PLACE OF DEATH *Jun 18 1937*
 County *De Witt* Registration District No. *1035* File No. *19912*
 Township *Current* Primary Registration District No. *5371* Registered No. *4*
 City (No. St. Ward)
2. FULL NAME *George Harvey Hobson*
 (a) Residence, No. St. Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred *22* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (*write the word*) *married*
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *Josephine Hobson*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 11-18 37*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85- 5- 10
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Timber Man*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *self*
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) *Indiana*
13. NAME *George Hobson*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*
15. MAIDEN NAME *Tamar Ann Gibson*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*
17. INFORMANT (ADDRESS) *Mrs Josephine Hobson Cedar Grove Mo.*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Ohio Iowa* DATE *19*
19. UNDERTAKER (ADDRESS) *W. D. Hobson Salem Mo.*
20. FILED *5/22* 19*37* *J. A. Kiscock* Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 21* 19*37*
22. I HEREBY CERTIFY, That I attended deceased from *May 16* 19*37*, to *May 20* 19*37*
 I last saw him alive on *May 20* 19*37*. Death is said to have occurred on the date stated above, at *12:30 a.m.*
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia Date of onset *5-16/37*
107
 Other contributory causes of importance:
Acute Bronchitis *5-14/37*
Fervid cough
 Name of operation _____ Date of _____
 What test confirmed diagnosis? *Urinalysis* as 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) *W. D. Hobson* M. D.
 (Address) *Salem, Mo.*

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 De Witt
Township Current
City _____ (No. _____, St. _____, Ward _____)

Registration District No. 1035
Primary Registration District No. 0371

File No. 19912
Registered No. _____

2. FULL NAME

George Harvey Hapson

(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) married

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

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

7. AGE YEARS 75 MONTHS 5 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
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)

FATHER

13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE June 1 1937

19. UNDERTAKER (ADDRESS) _____

20. FILED 6/22 1937 J. A. Knaeok Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 31 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
If so, specify _____

(Signed) Lloyd H. Hunt, M. D.
(Address) Salem Mo

SUPPLEMENTARY

5-19912