

Dr. Rambo

MAR 9 1939

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

6283

Do not use this space.

1. PLACE OF DEATH

(a) County Cole Registration District No. 213
(b) Township _____ Primary Registration District No. 3014 Registered No. 34
(c) City Jefferson (d) Street No. St. Mary's Hospital St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mabel Hornbuckle

(a) Residence, No. Warwick Hotel, St. Louis, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May-19-1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
41 8 15

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Saleslady
9. Industry or business in which work was done, as 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) Carroll County, Mo13. NAME William H. Edwards14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone County, Mo.15. MAIDEN NAME Emma Wiggins16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone County, Mo.17. INFORMANT Mrs. John George
(ADDRESS) Jefferson City, Missouri18. BURIAL, CREMATION, OR REMOVAL PLACE River View Cemetery DATE Feb-7-193919. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Rambo
Jefferson City, Mo.20. FILED 2/27/39 W. H. Rambo
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1939, to Feb. 4th, 1939.
I last saw h.c. alive on Feb. 4, 1939. 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:

Edema of Brain

Date of onset

Other contributory causes of importance:

appendicitis subacute
myomata uterus
Ovarian cyst rt.

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 W. H. Rambo, M. D.
(Signed) __________, (Address) G. C. Mc

121
JUL - 7 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Joseph J. Gordon

working under my personal supervision.

Registered Apprentice No.....

Joseph J. Gordon

Signed

Licensed Embalmer No.....

P. O. Address.....

*1986
Jefferson City Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

6283
Do not use this space.

1. PLACE OF DEATH
 (a) County Cole Registration District No. 213
 (b) Township _____ Primary Registration District No. 3014 Registered No. _____
 (c) City Jefferson (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mabel Hornbuckle
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (specify the word) Div

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.
	<u>41</u>	<u>8</u>	<u>15</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as 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 _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 2/7/1939 M. Beasly Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 4, 1939

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

I last saw h. _____ 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:
Edema of Brain
12/1

Other contributory causes of importance:
Appendicitis Sub-acute
Myomet. uterus ovarian cyst Rt. - non malignant

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) A. W. Rambo _____, M. D.
 (Address) Jefferson City Mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

