

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**

22687
Do not use this space.

REC'D JUL 2 1939

1. PLACE OF DEATH **Mercer**

(a) County **Mercer** Registration District No. **553**
 (b) Township **Marion** Primary Registration District No. **5746** Registered No. **11**
 (c) City _____ (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 **76** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Wm. Mobley**

(a) Residence, No. **R. F. D. Mercer Missouri 1** 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 **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 **Susan Mobley**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 6, 1859.**

7. AGE YEARS **79** MONTHS **II** DAYS **13** If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Farmer**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Own farm**
 10. Date deceased last worked at this occupation (month and year) **May 1938** 11. Total time (years) spent in this occupation **Admission Lifetime**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Va. /**

FATHER 13. NAME **Silas Mobley /**

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio /**

MOTHER 15. MAIDEN NAME **Rebecca Buchanan**

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**

17. INFORMANT (ADDRESS) **Mrs. Sam Williams
Lineville Iowa**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Lineville Ia.** DATE **June 21, 1939**

19. FUNERAL DIRECTOR (ADDRESS) **O. O. Brubaker
Lineville Iowa**

20. FILED **420 1939 S. P. Davis** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **June 19 1939**

22. I HEREBY CERTIFY That I attended deceased from **March 1 1939** to **June 19 1939**
 I last saw him alive on **June 19 1939** Death is said to have occurred on the date stated above, at **4:30 P. M.**
 The principal cause of death and related causes of importance were as follows:

Carcinoma of Prostate gland - 1-39

Other contributory causes of importance: **51**

Name of operation **none** Date of _____
 What test confirmed diagnosis? **Biopsy** 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) **S. P. Davis** M. D.
 (Address) **Lineville Mo.**

RECEIVED

District Health Officer No. 11,

District File Number 739-277

Date Filed JUL 7 1939

STATEMENT BY LICENSED EMBALMER

I, O. O. Grumble, Licensed Embalmer No. 872

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Amos L. Grumble

L. E. 3967

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed O. O. Grumble
Licensed Embalmer No. 872

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.)