

FILED APR 12 1940
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1002

Registrar's No. **995**

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 days
 (Specify whether
 In this community 23
 years, months or days)

3. (a) PRINT
FULL NAMESamuel C. Cobb

3. (b) If veteran,

name war no

3. (c) Social Security

No. 496-09-9217

4. Sex

Male5. Color or
race White6. (a) Single, widowed, married,
divorced Married

6. (b) Name of husband or wife

Lda Cobb6. (c) Age of husband or wife if
alive 66 years

7. Birth date of deceased

Dec 3 1887

(Month)

(Day)

(Year)

8. AGE:

Years

52

Months

2

Days

3

If less than one day

hr. _____ min.

9. Birthplace

(City, town, or county)

(State or foreign country)

Neb

10. Usual occupation

WPA

11. Industry or business

MOTHER FATHER

12. Name John W. Cobb

18. Birthplace

(City, town, or county)

(State or foreign country)

Ind.14. Maiden name Mary Dishman

15. Birthplace

(City, town, or county)

(State or foreign country)

Ky

16. (a) Informant's own signature

Ida Cobb

(b) Address

1521 Charolett17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Nar. 5 1940

(Month) (Day) (Year)

(c) Place: burial or cremation

Elmwood

18. (a) Signature of funeral director

Mrs. C. L. Forster

(b) Address

918 Brooklyn K. & MO19. (a) 3-4-40

(Date received local registrar)

(b) M. M. Crowe

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1521 Charlotte
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2nd
 year 1940 hour 1 minute 40 A.M.

21. I hereby certify that I attended the deceased from
2-19-40, 19____, to 3-2-40, 19____;

that I last saw him alive on 3-2-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma of prostate with gangrenous
cystitis and pyelonephritis

Due to _____

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Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy

See above

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____

(Specify type of place)

(e) Means of injury 1

23. Signature P. D. A. Mansa M.D. (M. D. or other) _____
Supt. K.C. Gen. Hospital, K.C. Mo.
 Address _____ Date signed _____

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address N.C. inst

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.