

Registration District No. 2Primary Registration District No. 202Registrar's No. 63

1. PLACE OF DEATH:

- (a) County Andrew
 (b) City or town Rosendale
 (If outside city or town limits, write "RURAL" and name of township)
Rosendale 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution X
 In this community Twenty years (Specify whether years, months or days)

3. (a) PRINT FULL NAME ISABEL IRENE HOBSON3. (b) If veteran, name war _____ 3. (c) Social Security No. XX

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife John F. Hobson 6. (c) Age of husband or wife if alive 83 years
 7. Birth date of deceased April - 3 - 1853
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 8 9 hr. min.9. Birthplace Galdwell co Mo
 (City, town, or county) (State or foreign country)10. Usual occupation Housewife 9

11. Industry or business

- MOTHER FATHER { 12. Name Jesse Snider 9
 18. Birthplace unknown 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Jane Robinson
 15. Birthplace unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Isabel Hobson(b) Address Galumet Mo17. (a) _____ (b) Date thereof 12-13-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Fairview cemetery18. (a) Signature of funeral director In Fred Terhune(b) Address Savannah Mo19. (a) Dec 23, 1940 (b) M. Wood
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Andrew
 (c) City or town Rosendale
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11
 year 1940 hour 7 AM minute _____ M.21. I hereby certify that I attended the deceased from Dec 6
1940 to Dec 11, 1940
 that I last saw him alive on Dec 11, 1940
 and that death occurred on the date and hour stated above.Immediate cause of death Sublethral Aboluscular 4 days
 Duration
 Due to Paralysis Sublethral

Due to _____

Other conditions Infection
 (Include pregnancy within 3 months of death)Major findings: none
 Of operations

Of autopsy _____

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 _____

23. Signature A. Kelly (M. D. or other)Address Bolivar Date signed Dec 40

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

Signed

J. Fred Terhune

Licensed Embalmer No. *1279*

P. O. Address. *Savannah*
me

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41687

Registration District No. 2

Primary Registration District No. 202

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Andrew

(b) City or town Rosendale
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Isabel Irene Hobson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 87 Months 8 Days 9 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 11 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction

Due to Paralysis Intestines

Due to Cause Unknown

Other conditions Seizures (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

S-41687