

1. PLACE OF DEATH:

(a) County Madaway
(b) City or town Parrell
(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 _____
years, months or days) _____

3. (a) PRINT FULL NAME JAMES C. JOBE

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased 21:54 = 1954
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 1 10 hr. min.

9. Birthplace Westmoreland Co. Penn
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name W.B. Jobe

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

14. Maiden name Athelene Wall

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

16. (a) Informant Mary Jobe

(b) Address Parrell, Mo.

17. (a) Burial (b) Date thereof 1-2-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parrell Cemetery

18. (a) Signature of funeral director A.C. Duffler

(b) Address Grant City, Mo.

19. (a) 2-1-41 (b) Wallace Kennedy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madaway
(c) City or town Parrell
(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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
year 1940 hour 200 minute 30 P.M.

21. I hereby certify that I attended the deceased from 12-30, 1940, to 12-31, 1940
that I last saw him alive on 12-30, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage - 3 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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

(a) Accident, suicide, or homicide (specify) no

(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?

5-14 While at work? (Specify type of place) (e) Means of injury

23. Signature B. J. Ross M.D. (M. D. or other) D

Address Grant City Mo Date signed 1-7-41

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

74
00

74
0
0

Direction

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Arch C. Dumble

Licensed Embalmer No..... *3252*

P. O. Address.....

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.