

STANDARD CERTIFICATE OF DEATH

Registration District No. 907

Primary Registration District No. 6220

Registrar's No. 7

I. PLACE OF DEATH:

- (a) County WRIGHT
 (b) City or town PLEASANT VALLEY - TWP - RURAL
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 10-11-6 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MISSOURI (b) County WRIGHT
 (c) City or town PLEASANT VALLEY TWP. O
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6 mile W. - Cedar Gap Mo
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 19
 year 1941 hour 6 minute 30 P. M.
 21. I hereby certify that I attended the deceased from May 15
1941, to May 19, 1941
 that I last saw h. alive on May 19, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Stroke
of the brain
 Duration _____

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

Major findings:
 Of operations 24
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

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? _____

(Specify type of place)
 (e) Means of injury _____
 23. Signature [Signature] (M. D. or other) D194
 Address 20200 St Date signed 5/21

3. (a) PRINT FULL NAME Harley Ray Cobb
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced SINGLE
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 13 1930
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>10</u>	<u>11</u>	<u>6</u>	hr. _____ min. _____

9. Birthplace Cedar Gap, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____
 12. Name Samuel B. Cobb
 13. Birthplace AVA, Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name MARILINA SPARKS
 15. Birthplace NORWOOD, Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Samuel B. Cobb
 (b) Address MANSEFIELD MO

17. (a) BURIAL (b) Date thereof May 21-41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Cedar Gap, Com.

18. (a) Signature of funeral director [Signature]
 (b) Address MANSEFIELD MO.
 19. (a) May 24, 1941 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

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

24-

RECEIVED

District Health Officer No. 6,

District File Number 671-869

Date Filed JUN 6 1941

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 W.A. Steffe

Licensed Embalmer No. 3221

P. O. Address Manfull Wis

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.