

SEP 9 1943 294
Registration District No. 294

Primary Registration District No. 6006

State File No. 170 H-9
Registrar's No.

1. PLACE OF DEATH:

(a) County: Randolph
(b) City or town: Rural Cairo
(c) Name of hospital or institution: R.F.D. #1 Cairo
(d) Length of stay: In hospital or institution: none
In this community: 23 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Randolph
(c) City or town: Rural Cairo
(d) Street No.: R.F.D. #1 Cairo
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME

LEORA COBB

3. (b) If veteran name war: none

3. (c) Social Security No.: none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2nd year 1943 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from 8-1-1943 to 8-1-1943

that I last saw her alive on 8-1-1943 and that death occurred on the date and hour stated above.

Immediate cause of death: General debility Duration 2 yrs

Due to Stroke of paralysis Left side complete Duration 2 yrs

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

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced, widowed: 2 divorced widowed
6. (b) Name of husband or wife: Jackson Cobb 6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: January - 17 - 1865 (Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 16 If less than one day hr. min.

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

10. Usual occupation: Housewife (Retired)

11. Industry or business:

12. Name: Jacob Hendershot

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

14. Maiden name: Lydia Johnston

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

16. (a) Informant: Willie W. Cobb

(b) Address: R.F.D. #1 Cairo Mo.

17. (a) Burial, cremation, or removal: Rural (b) Date thereof: Aug - 4 - 1943 (Month) (Day) (Year)

(c) Place: burial or cremation: Pleasant View

18. (a) Signature of funeral director: Snow Funeral Home

(b) Address: Proberty Mo.

19. (a) 8-4-43 (Date received local registrar) Irma Havi (Registrar's signature)

23. Signature: G. L. McCormick (M. D. or other M.D.) Address: Proberty Mo. Date signed: 8-3-43

RECEIVED

District Health Officer No. 10

District File Number 9-43-1461

Date Filed SEP 8 1943

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

R. J. Carter

Licensed Embalmer No. 4117

P. O. Address Moberly, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 294

Primary Registration District No. 6006

Registrar's No. 170

SEP 10

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Rural Cairo Twp
(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 Leora Cobb
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 W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 17 1878
(Month) (Day) (Year)
8. AGE: Years 78 Months 6 Days 2 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 2
Year 1943 Hour _____ minute _____ M.

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

Immediate cause of death General debility
Stroke of paralysis
Left side complete
Cerebral hemorrhage

Due to _____
Due to _____

Other conditions (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? _____

(Specify type of place)
While at work? _____ (a) Means of injury _____

23. Signature L. McCormick (M. D. or other) _____
Address insberly mo Date signed 8-13-43

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

29124