S. No. 2
DM—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1944

Registration District No. 7

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27518

Primary Registration District No. 3012

Registrar's No. 119

1. PLACE OF DEATH:
(a) County Cedar
(b) City or town Ex Jefferson Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mitchell Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 46 days (Specify whether years, months or days)
In this community about 40 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County Johnson
(c) City or town West Branch
(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

3. (a) PRINT FULL NAME Clare Marie Hobendall
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alfred J. Hobendall
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased June (Month) 28 (Day) 1886 (Year)

8. AGE: Years 58 Months 1 Days 14 If less than one day hr. min.

9. Birthplace Johnson Co. (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Jens Thompson
13. Birthplace Denmark (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Anderson
15. Birthplace Denmark (City, town, or county) (State or foreign country)
16. (a) Informant Alfred J. Hobendall
(b) Address West Branch, Iowa.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 11-44 (Month) (Day) (Year)
(c) Place: burial or cremation West Branch Iowa.
18. (a) Signature of funeral director Claude Prichard
(b) Address Excelsior Springs, Mo.
19. (a) 8-11-44 (Date received local registrar) Mrs Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11 year 1944 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from 7-1-44, 19..., to 8-11, 1944 that I last saw her alive on 8-11, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to Cerebral Sclerosis	
Due to	
Other conditions Had Cerebral Hemorrhage 4 yrs ago. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN — 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)
While at work (e) Means of injury
23. Signature (M. D. or other)
Address Excelsior Springs, Mo. Date signed 8-11-44

(Licensed Embalmer's Statement on Reverse Side)

NOV 29 1944

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-7-44

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 Earl Ralph

Licensed Embalmer No. 3455-F

P. O. Address St. Louis, Mo.

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, fact should be so stated above.