

Registration District No. 93

Primary Registration District No. 4155

1. PLACE OF DEATH:

(a) County DADE

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

(c) Name of hospital or institution: NONE  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONE (Specify whether)

In this community LIFE years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DADE

(c) City or town EVERTON  
(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 TYCA ANN COBLE

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 9  
year 1944 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 8  
1944 to DEC. 9 1944

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife BENJAMIN 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: JANUARY 13 1871  
(Month) (Day) (Year)

that I last saw her alive on Dec. 9 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death CORDARY THROMBOSIS Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day

73 10 26 hr. min.

Due to FRACTURE OF R. HUMERUS  
DUE TO FALL

Due to \_\_\_\_\_

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

10. Usual occupation HOUSE HOUSEWIFE

11. Industry or business NONE

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 168  
Of operations 178

MOTHER FATHER { 12. Name NO RECORD

13. Birthplace NO RECORD  
(City, town or county) (State or foreign country)

14. Maiden name NO RECORD

15. Birthplace NO RECORD  
(City, town, or county) (State or foreign country)

Of autopsy \_\_\_\_\_

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

16. (a) Informant FRED FUNK

(b) Address EVERTON, MO

17. (a) BURIAL (b) Date thereof 12-11-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ANTIOCH

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

(a) Accident, suicide, or homicide (specify) ACCIDENT - (FALL)

(b) Date of occurrence NOV. 8, 1944

(c) Where did injury occur? EVERTON DADE MO  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
IN HOME

18. (a) Signature of funeral director James E. Smalley

(b) Address Summit, Mo.

19. (a) 12/11/1944 (b) Phyllis Lack  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury FALL

23. Signature A. F. Starn (M.D. or other) DO

Address Everton, Mo. Date signed 12/11/44

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

29  
0  
0

RECEIVED  
District Health Officer No. 6,  
District File Number 1425-128  
Date Filed JAN 22 1945

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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 Sam E. Sencer  
Licensed Embalmer No. 4099  
P. O. Address Shenfield 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.