

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1207A  
Registrar's No. 1782

FILED MAY 3 1945  
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1410 Oakley  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 57 years  
In this community 57 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Jackson  
(c) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1410 Oakley  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ADA C. COBB  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Charles C. Cobb  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 8 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 9 12  
hr. min.

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

10. Usual occupation House wife

11. Industry or business at home

12. Name Martin David Hudson

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

14. Maiden name Sarah Ellen Crow  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Ada Mae Trotter

(b) Address 1410 Oakley

17. (a) REMOVAL (b) Date thereof 4/20/1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deepwater Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 4-21-45 (b) Sherildine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20th.  
year 1945 hour 6 minute 15 A. M.  
21. I hereby certify that I attended the deceased from April 10-45  
\_\_\_\_\_ 19\_\_\_\_ to April 20 1945  
that I last saw h. alive on April 13- 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute dilatation of heart  
Due to arterio sclerosis  
Chronic Myocarditis

Other conditions (Include pregnancy within 3 months of death) 93d

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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury MA  
23. Signature J. Quincy Anderson (M. D. or other)  
Address 6520 W. 2nd Ave Date signed 4-20-45

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

Dr. Conley Anderson  
656 1/2 Indep. Ave. Be D 756

AUG 4 1949

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed

*Le H. Wise*

Licensed Embalmer No. *7570*

P. O. Address

*100 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.**