

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17788

FILED JUN 7 1945

Registration District No. 2052

Primary Registration District No. 2052

Registrar's No. 116

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 612 W. Cooper  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 20 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARTHA HOBBS

3. (b) If veteran, name war. No. 3. (c) Social Security No.

4. Sex M 3. Color or race W  
5. (a) Single, widowed, married divorced  
6. (b) Name of husband or wife Wm E. Hobbs  
6. (c) Age of husband or wife if alive 14 years  
7. Birth date of deceased 6 (Month) 18 (Day) 75 (Year)

8. AGE: Years 70 Months 11 Days 13 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Self

12. Name Lewis Presley

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

14. Maiden name Octavia Williams

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

16. (a) Informant Wm E. Hobbs

(b) Address Harvard Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Mo

18. (a) Signature of funeral director J. D. Ferguson

(b) Address 117 E. Jefferson Sedalia Mo

19. (a) 5-4-45 (Date received local registrar) (b) Mrs Anna Peyer (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis  
(c) City or town Sedalia (If outside city or town limits, write "RURAL")  
(d) Street No. 612 W. Cooper (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1945 hour Eleven minute 45 A. M.

21. I hereby certify that I attended the deceased from Mar 16 - 1945 to May 2 - 1945 that I last saw her alive on May 2 and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral apoplexy  
Due to Chronic latantital defects  
Due to

Other conditions Hypertension  
(Include pregnancy within 6 months of death)

Hemiplegia

Major findings:

Of operations

131K

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? (c) Means of injury

23. Signature A. R. Maddox (M. D. or other) M. D.  
Address 116 E. W. Main Date signed 5-4-45

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 6/6/45

STATEMENT BY LICENSED EMBALMER

JUL 5 1945

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 \_\_\_\_\_

Licensed Embalmer No. 2172

P. O. Address Sedalia

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.