

FILED JUL 26 1945

Registration District No. 17 Primary Registration District No. 4278 5657 Registrar's No. 24

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Miller R.R.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: South of Residence 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community Four Months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Miller Mo. R.R. 1
(If outside city or town limits, write "RURAL.")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? ← (Yes or No)
If yes, name country ←

3. (a) PRINT FULL NAME

Irene Gobb

3. (b) If veteran, name war ←

3. (c) Social Security No. ←

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 5 - 24 - 1929
(Month) (Day) (Year)

8. AGE: Years 16 Months 0 Days 7 If less than one day hr. _____ min. _____

9. Birthplace Springfield Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name John Gobb
13. Birthplace Taney Co. Mo. 0
(City, town, or county) (State or foreign country)
14. Maiden name Grace Rathbun
15. Birthplace Springfield Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Grace M. Dykes
(b) Address 76 1/2 Hwy Mo. R.R. # 2
17. (a) Burial (b) Date thereof 6-5-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Morris Deiman
(b) Address Miller Mo.
19. (a) 7-9-1945 (b) Ama Johnson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1945 hour _____ minute _____ M.

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

Immediate cause of death Severed Jugular vein on left side
Due to shot from 22 Rifle

Due to _____
Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations _____
Of autopsy _____

Duration _____
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) not known
(b) Date of occurrence 7/1/45
(c) Where did injury occur? Lawrence Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Farm
While at work? No (Specify type of place) (e) Means of injury gun shot
23. Signature German Duridge (M.D. or other) Coroner
Address Acworth Mo. Date signed 7/1/45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 743-796

Date Filed III 24 1945

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 S. P. Leiman

Licensed Embalmer No. 3297

P. O. Address Miller 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.