S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 18 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26685

Registration District No. 1 Primary Registration District No. 5008 Registrar's No. 168

1. PLACE OF DEATH:

(a) County Adair Co.
(b) City or town Rural-Walnut Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Address Novinger!
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Novinger-Adair Co.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Emma Frances Mobley
3. (b) If veteran, name war X
3. (c) Social Security No. X
4. Sex Female
5. Color or race white
6. (a) ~~Single, widowed,~~ married, ~~divorced~~ married
6. (b) Name of husband or wife David J. Mobley
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased 4 (Month) 12 (Day) 1891 (Year)

8. AGE: Years	Months	Days	If less than one day
54	3	0	hr. min.

9. Birthplace Adair Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name John Baggs
13. Birthplace Oskaloosa (City, town, or county) Iowa! (State or foreign country)
MOTHER
14. Maiden name Nancy Parker
15. Birthplace Beardstown (City, town, or county) Ill. (State or foreign country)
16. (a) Informant Naomi A McFarland
(b) Address Green City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 (Month) 13 (Day) 1945 (Year)
(c) Place: burial or cremation Mt Carmel Cem
18. (a) Signature of funeral director Glenn E Kent & Son
(b) Address Green City Mo
19. (a) 7-18-45 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11 year 1945 hour 8 minute 30 P M.
21. I hereby certify that I attended the deceased from July 6, 1945 to July 6, 1945 that I last saw her alive on July 6, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Fatty Degeneration of the Heart,

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

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)
(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 W E Munn (M. D. ~~or other~~)
Address Novinger, Mo Date signed 7/14/45

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-45-1329
Date Filed AUG 16 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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green Castle, Ind.

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.