

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30974

State File No. \_\_\_\_\_

FILED SEP 20 1945  
Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 261

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Elizabeth Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Sharon Elaine Cobern

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 September 6, 1945  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation XX

11. Industry or business XX

12. Name Alfred Cobern

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

14. Maiden name Ellen Leeds

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

16. (a) Informant Alfred Cobern

(b) Address Bluffs Kinderhook Ill.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45  
(Month) (Day) (Year)

(c) Place: burial or cremation Kinderhook

18. (a) Signature of funeral director Wm. M. Smith

(b) Address 902 Broadway

19. (a) 9-11-45 (Date received local registrar) (b) W. E. Lucke (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Pike 999  
(c) City or town Kinderhook 11  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 2  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 9  
year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9-6-45  
19 \_\_\_\_\_ to 9-9-45 19 \_\_\_\_\_  
that I last saw him alive on 9-9-45 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Duration 30 days

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

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 159

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

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? \_\_\_\_\_

(f) While at work \_\_\_\_\_ (Specify type of place) (g) Means of injury \_\_\_\_\_

23. Signature J. E. Duffman (M. D. or other) MD  
Address Hannibal Mo. Date signed 9/10/45

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

**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.

**This body was not embalmed**

Signed.....  
.....  
Licensed Embalmer No.....  
P.O. Address.....

**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.**