DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41609

FILED DEC 21 1945

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede 53

(c) City or town Lebanon 1
(If outside city or town limits, write "RURAL")

(d) Street No. 204 Harwood 2
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Dr James Albert McComb

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex M 1

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Laura May Spiller

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov. (Month) 10, (Day) 1863 (Year)

8. AGE: Years 82 Months – Days 5 If less than one day hr. min.

9. Birthplace Lebanon Laclede Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Physician

11. Industry or business

MOTHER FATHER

12. Name James M. Comb

13. Birthplace Jacksonville Ill. 1 (City, town, or county) (State or foreign country)

14. Maiden name Mary Holman

15. Birthplace North Carolina 1 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Henry Patton

(b) Address Lebanon Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-45 (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. E. Holman

(b) Address Lebanon, Mo.

19. (a) 11-4-45 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15 year 1945 hour 10 minute A.M.

21. I hereby certify that I attended the deceased from May 15, 1944, to Nov 15, 1945, that I last saw him alive on Nov. 14, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	2 days
Due to: Cardiovascular renal	
Due to: disease	5 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 3/10	

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 0

23. Signature Joseph L. Hope (M. D. ~~or other~~)

Address Lebanon, Mo. Date signed 11/10/45.

1463 (Licensed Embalmer's Statement on Reverse Side)

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

Received .....
Laclede County Health Unit
File No. 11-45-170
Date Filed 12/18/45

OCT 2 1953

FEB 11 1946

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 Dorsey N. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.