

No. 2
-3-43
5-17-39
K37823

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 5 2 1946

Registration District No. 532 Primary Registration District No. 3127 Registrar's No. 103

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:
Jane Chinn Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Hrs. (Specify whether
In this community 58 yrs. years, months or days)

3. (a) PRINT FULL NAME Carl H. Hobart

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Susie Hobart 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Feb. 17 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

65 4 17 hr. min.

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

10. Usual occupation Retired Frisco Passenger

11. Industry or business Frisco Railroad

12. Name George J. Hobart

13. Birthplace No Data Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Malissa Strain

15. Birthplace No Data Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Susie Hobart (Wife)

(b) Address 608 Oakland St. WEBB CITY, MO

17. (a) Burial (b) Date thereof JULY 8; 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cem.

18. (a) Signature of funeral director Hedge Lewis

(b) Address Webb City, Mo

19. (a) JULY 7; 46 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 608 Oakland St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4
year 1946 hour I minute 30 A.M.

21. I hereby certify that I attended the deceased from July 3 1946 to July 4 1946
that I last saw him alive on July 3 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 5 hours

Due to _____

Due to _____

Other conditions 1
(Include pregnancy within 3 months of death)

Major findings:
Of operations gbc

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

Signature [Signature] (M. D. or other) _____
Address Webb City, Mo Date signed 7/7/46

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

22905

9
6
2

49
6
2

127

46-7-599

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 *Richard Gray Lewis*

Licensed Embalmer No. *4403*

P. O. Address *Webb City, 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.