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Dr. Name  
32476

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. 360

Primary Registration District No. 6224

Registrar's No. 112

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Vernon Co. Rural Cemetery  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
At Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days) many years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon <sup>108</sup>

(c) City or town Vernon Co.  
(If outside city or town limits, write "RURAL")

(d) Street No. Rural - Centre Sup.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Anna Belle Goblish

3. (b) If veteran, name war ✓

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 20 1869  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1946 hour 8 minute 10 a.m.

21. - I hereby certify that I attended the deceased from Feb 29 1946 to Aug 29 1946  
that I last saw her alive on 8-28 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary thrombosis with myocardial infarction

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy 94A

8. AGE: Years 77 Months 3 Days 9 If less than one day hr. min.

9. Birthplace Minneapolis (City, town, or county) Ill. (State or foreign country)

10. Usual occupation Homekeeper

11. Industry or business \_\_\_\_\_

12. Name Geo. W. Sullivan

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

14. Maiden name Stannah Lancaster

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

16. (a) Informant Mrs. Bob Warren

(b) Address P.O. Nevada Mo.

17. (a) Cremial (Burial, cremation, or removal) (b) Date thereof 8-31-46 (Month) (Day) (Year)

(c) Place: burial or cremation Depressed Cemetery

18. (a) Signature of funeral director Ray Funeral Service (Specify type of place) while at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

(b) Address Nevada Mo.

19. (a) 9-9-46 (Date received local registrar) (b) Matthew Yancey (Registrar's signature)

Duration 20 days

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? \_\_\_\_\_

23. Signature Robert Ows (M. D. or other) \_\_\_\_\_  
Address Nevada Mo. Date signed 8-30-46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number 9-46-969

Date Filed 10-2-46

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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 Allen J. Keys

Licensed Embalmer No. 1968

P. O. Address Nevada, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 008Registration District No. 360Primary Registration District No. 6224Registrar's No. 112

## 1. PLACE OF DEATH:

- (a) County Dernon  
 (b) City or town Sumner - Center Twp.  
 (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 days3. (a) PRINT  
FULL NAME Anna B. Koberk

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

4. Sex
- F
5. Color or race
- W
6. (a) Single, widowed, married, divorced
- wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_
- 
- (Month) (Day) (Year)

8. AGE: Years
- 77
- Months
- 3
- Days \_\_\_\_\_
- 
- If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_
- 
- (City, town or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

- MOTHER FATHER } 12. Name \_\_\_\_\_  
 } 13. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)  
 } 14. Maiden name \_\_\_\_\_  
 } 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

- (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_
- 
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

- (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b)
- Kathryn Yancey
- 
- (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_

- (c) City or town \_\_\_\_\_
- 
- (If outside city or town limits, write "RURAL")

- (d) Street No. \_\_\_\_\_
- 
- (If rural, give location)

- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_
- 
- year
- 1946
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

## 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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

32476