

No. 2  
-1/47  
5-17-39

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **42775**

FILED JAN 7 1948  
Registration District No. **3948**

Primary Registration District No. **3061**

Registrar's No. **431**

94  
5  
2

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

1. PLACE OF DEATH

(a) County... **St. Francois**

(b) City or town... **Flat River, Mo**  
(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... **years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... **Missouri** (b) County... **St. Francois**

(c) City or town... **Flat River, Mo**  
(If outside city or town limits, write "RURAL")

(d) Street No. **5**  
(If rural, give location)

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

If yes, name country **0**

3. (a) PRINT FULL NAME **Agnes K. Hobbins**

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7<sup>th</sup>** day **Dec**  
year **1947** hour **9 AM** minute..... M.

4. Sex **F** 5. Color or race **W**

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

6. (b) Name of husband or wife... **W. K. Hobbins**

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

7. Birth date of deceased **June 12 1866**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May**, 19**46**, to **Dec 7**, 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death **cranclo pneumonia**

Duration **3 days**

8. AGE: Years **81** Months **6** Days **6** If less than one day hr. min.

Other conditions... **arterio-sclerosis -**

Refer to previous, aortic & ventricular

Major findings: **sequestration**

Of operations.....

Of autopsy... **g2**

9. Birthplace... **Ind.**  
(City, town, or county) (State or foreign country)

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? (c) Means of injury **0**

10. Usual occupation... **Housework**

11. Industry or business... **distiller**

12. Name... **unknown**

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

14. Maiden name... **unknown**

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

PHYSICIAN

Underline the cause of which death should be charged statistically.

16. (a) Informant... **Catherine Donnell**

(b) Address... **Flat River, Mo**

17. (a) **Burial** (b) Date thereof **12-9-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) **Parsoness Pamela**  
Place of burial or cremation

18. (a) Signature of funeral director... **Baldwell Buss**

(b) Address... **Flat River, Mo**

19. (a) **1-2-48** (b) **Cether Rudloff**  
(Date received local registrar) (Registrar's signature)

23. Signature **H. O. O'Leary** (M. D. or other)

Address **Derby, Mo** Date signed **12-18-47**

RECEIVED

District Health Officer No. 4  
District File Number 148-18  
Date Filed 1-6-47

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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 W. A. Baldwin

Licensed Embalmer No: 3317

P. O. Address Flat River 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.