

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

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7515**
Registrar's No. **24**

FILED FEB 18 1948
Federal Office of Vital Statistics

Registration District No. **203**

Primary Registration District No. **3074**

1. PLACE OF DEATH:

(a) County **Leath**

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

(c) Name of hospital or institution **S. A. HESTON GENERAL HOSPITAL**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2-4 hrs**
(Specify whether **44 YEARS**)

In this community **44 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **New Madrid**

(c) City or town **New Madrid**
(If outside city or town limits, write "RURAL")

(d) Street No. **72**
(If rural, give location) **4**

(e) Citizen of foreign country? **NO** (Yes or No) **1**
If yes, name country

3. (a) PRINT FULL NAME **OMEGA DOBBS**

3. (b) If veteran, name war **NO**

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

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

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

6. (b) Name of husband or wife **Jessie Dobb**

6. (c) Age of husband or wife if alive **20** years **15** years

7. Birth date of deceased (Month) (Day) (Year) **1928**

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

19 **7** **20** hr. min.

9. Birthplace **Bourbon County Ky. 1**
(City, town or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **None**

12. Name **Sam Jites**

13. Birthplace **Mo Ky 1**
(City, town or county) (State or foreign country)

14. Maiden name **Etta Lee O'Neil**

15. Birthplace **Mo Ky 1**
(City, town or county) (State or foreign country)

16. (a) Informant **Jessie Dobb**

(b) Address **New Madrid Mo**

17. (a) Burial, cremation, or removal **Buried**

(b) Date thereof **2/6-48**
(Month) (Day) (Year)

(c) Place: burial or cremation **Wickliff Ky**

18. (a) Signature of funeral director **Richard Dobb Co**

(b) Address **New Madrid Mo**

19. (a) **2-13-48** (b) **Mr. P. F. Henry**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **5** year **1948** hour **11:30** minute **2:30** P. M.

21. I hereby certify that I attended the deceased from **2-4-48** to **2-5-48**, 19**48**, that I last saw her alive on **2-5-48** and that death occurred on the date and hour stated above.

Immediate cause of death **Respiratory failure**

Due to **Pneumonia**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Underline the cause of death which should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? Means of injury

23. Signature **Alben P. Sargent** (M. D. or other) **M.D.**

Address **Sikeston, Mo.** Date signed **2-11-48**

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

MOTHER FATHER

APR 6 1948

JAN 12 1949

RECEIVED

District Health Office No. 2

District File Number 248-220

Date Filed 2-16-48

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 _____

Allen C. McGovern Registered Apprentice No. 512

working under my personal supervision.

Signed [Signature]

Licensed Embalmer No. 3803

P. O. Address New Madrid, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. mauch

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Lickston
(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 _____ (Specify whether _____)
years, months or days

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 _____

3. (a) PRINT FULL NAME

Omega Dobler

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased June 15 (Month) (Day) (Year)

8. AGE: Years 19 Months 7 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day _____ year 1948 hour _____ minute _____ M.

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

Immediate cause of death Respiratory failure Duration _____

Due to Pneumonia

Due to Lobar pneumonia

Other conditions Occurring in all five lobes

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 108

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

1948

S-7515

Arthur P. Barrett
1948