FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 7 1948

Registration District No. 184

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3038

State File No. 26932

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Linn

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

(c) Name of hospital or institution: 310 West Brooks St. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 7 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58

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

(d) Street No. 310 West Brooks St. 2
(If rural, give location) 0

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

If yes, name country .....

3. (a) PRINT FULL NAME Mollie Maud Jobe

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife James F. Jobe

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased December 14, 1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
54	8	8	..... hr. ..... min.

9. Birthplace Humphreys, Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Robert D. Glaze
13. Birthplace Reger, Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine Meekins
15. Birthplace Humphreys, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant James F. Jobe
(b) Address Brookfield, Mo.

17. (a) Burial (b) Date thereof 8-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Harold B. Wright
(b) Address Brookfield, Mo.

19. (a) 8-24-48 (b) Walter B. Irwin 167
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22
year 48 hour 12 minute 15 a M.

21. I hereby certify that I attended the deceased from Dec. 3, 1947, to Aug. 22, 1948, that I last saw her alive on Aug 22, 1948, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cachexia	3 wks.
Due to: Spindle cell sarcoma of body of uterus	2 years
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

48B

PHYSICIAN

Underline the cause of 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 .....

23. Signature Ralph W. Robinson (M. D. or other)

Address Brookfield Mo. Date signed 8/23

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 .....

Licensed Embalmer No. 3718

P. O. Address Brookfield 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.