No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 18 1948

Registration District No. 3068

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5724

State File No. 37315

Registrar's No. 397

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

1. PLACE OF DEATH:
(a) County: Macon
(b) City or town: Rural Eagle Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: none (Specify whether years, months or days)
In this community: lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Macon 61
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location) 5
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: ATLA I DOBBS
3. (b) If veteran, name war: none
3. (c) Social Security No.: none
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: Div
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Sept. (Month) 24 (Day) 1897 (Year)
8. AGE: Years 50 Months 11 Days 25 If less than one day hr. min.
9. Birthplace: Brown Co (City, town, or county) Ill (State or foreign country)
10. Usual occupation: housewife
11. Industry or business: self
FATHER
12. Name: Alf Howell
13. Birthplace: Brown Co (City, town, or county) Ill (State or foreign country)
MOTHER
14. Maiden name: Kate Stivers
15. Birthplace: Brown Co (City, town, or county) Ill (State or foreign country)
16. (a) Informant: Family
(b) Address:
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-48 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Woodlawn Cemetery
18. (a) Signature of funeral director: Stephens & Hoskins
(b) Address: Macon Mo.
19. (a) Nov 10-48 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19 year 1948 hour 12 minute 10 P.M.

21. I hereby certify that I attended the deceased from June 1948, to Sept 19 1948, that I last saw h. alive on Sept 19 1948, and that death occurred on the date and hour stated above.

Duration

Immediate cause of death:

Due to: Chronic Endocarditis

Due to: Chronic nephritis

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

Major findings:
Of operations: 13 P
Of autopsy:

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: C. D. Edwards (M. D. or other)
Address: Macon Mo. Date signed 10/20/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 11-48-1970
Date Filed NOV 17 1948

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 C. L. Stephens

Licensed Embalmer No. 3059

P. O. Address Macon, 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.

No. 2B
1-3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dee

Registration District No. 200 Primary Registration District No. 5724 Registrar's No. 397

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Rural
(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 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 Atla J. Dobbs

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 Divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 24 (Day) 1899 (Year)

8. AGE: Years 50 Months 11 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-37315