

FILED AUG 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25970**

BIRTH NO.		REG. DIST. NO. 1	PRIMARY REG. DIST. NO. 3000	Registrar's No. 250
1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Schuyler		
b. CITY (If outside corporate limits, write RURAL and give township) Kirkville c. LENGTH OF STAY (In this place) 16 mo.		c. CITY (If outside corporate limits, write RURAL and give township) Downing		
d. FULL NAME OF HOSPITAL OR INSTITUTION Community Nursing Home #1		d. STREET ADDRESS (If rural, give location) 1		
3. NAME OF DECEASED a. (First) John b. (Middle) W. c. (Last) Mobley		4. DATE OF DEATH (Month) (Day) (Year) 8-14-49		
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify)	8. DATE OF BIRTH Apr 20, 83	9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mark, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Lewis Comer Mobley		13b. MOTHER'S MAIDEN NAME Annie Stogdill	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Mobley Downing Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malnutrition ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senile psychosis DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of Femur		INTERVAL BETWEEN ONSET AND DEATH 1 month year years 6 wks.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4800	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr 12, 1948 , to Aug 14, 1949 , that I last saw the deceased alive on Aug 14, 1949 and that death occurred at 5:15 a.m. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) M. S. Guttenbach D.O.		23b. ADDRESS Kirkville, Mo	23c. DATE SIGNED 8-13-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 15, 1949	24c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	24d. LOCATION (City, town, or county) (State) Kirkville, Mo.	
DATE REC'D BY LOCAL REG. 8-23-49	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Loyd Moore Downing Mo.		

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

RECEIVED AUG 29 1949
District Health Officer No. 10
District File Number 849-1487
Date Filed AUG 29 1949

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Lloyd Moore

Licensed Embalmer No. 3137

P. O. Address Donning 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.