

FILED SEP 9 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26422**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **70** PRIMARY REG. DIST. NO. **5284** Registrar's No. **48**

1. PLACE OF DEATH a. COUNTY <b>Clark</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Clark</b>	
b. CITY (If outside corporate limits, write RURAL, and give town) <b>Alexandria</b>	c. LENGTH OF STAY (in this place) <b>10 yrs</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Alexandria</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Earnie</b>	b. (Middle)	c. (Last) <b>Scobee</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug 24 1949</b>
---	-------------	-------------------------	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 2-1889</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>22</b>	IF UNDER 1 HR. Hours <b></b> Min. <b></b>
--------------------	-------------------------------	---	-------------------------------------	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	-----------------------------------	---	--

13a. FATHER'S NAME <b>Robert Scobee</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Turnure</b>	14. NAME OF HUSBAND OR WIFE <b>Gladys Scobee</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>9/17/18 - 6/19/19</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OF NAME <b>Gladys Scobee</b>	ADDRESS <b>Alexandria, Mo.</b>
---	-------------------------	--	--------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma lower lobe of lung</b>		144X
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <b>Epithelioma mouth &amp; throat - 6 years ago</b> DUE TO (c) <b>operated</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **July**, 1946, to **Aug 25**, 1949, that I last saw the deceased alive on **Aug 25**, 1949, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>J. M. Piggis M.D.</b> (Degree or title)	23b. ADDRESS <b>U. Kalaha Mo.</b>	23c. DATE SIGNED <b>Aug 29 1949</b>
---	-----------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Aug. 27-1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Frazier</b>	24d. LOCATION (City, town, or county) (State) <b>Wayland - Mo.</b>
--	-------------------------------	---	--

DATE REC'D BY LOCAL REG. <b>8/31-49</b>	REGISTRAR'S SIGNATURE <b>W. D. Bridges</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. Suttner</b>	ADDRESS <b>Kalaha Mo.</b>
---	--	--	---------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

23  
0  
0

OCT 14 1949

RECEIVED SEP 6 1949  
District Health Officer No.  
District File Number 9-49-15  
Date Filed SEP 6 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Olis L. Guttery*

Licensed Embalmer No.

*7965*

P. O. Address

*Derry, N.H.*

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.