

FILED OCT 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33194

State File No. _____

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

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>356</u>	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>		c. LENGTH OF STAY (in this place) <u>2</u> <u>since 10-3-29</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u> <u>Mo</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 8 1949</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fulton State Hosp #1</u>				d. STREET ADDRESS (If rural, give location) <u>18</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u>		b. (Middle) <u>—</u>		c. (Last) <u>Hobbs</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>		8. DATE OF BIRTH <u>A.K.</u>	
9. AGE (In years last birthday) <u>70+</u>		IF UNDER 1 YEAR Days <u>A.K.</u>		IF UNDER 4 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>State of Kansas</u>	
13a. FATHER'S NAME <u>Dont know</u>				13b. MOTHER'S MAIDEN NAME <u>Dont know</u>		14. NAME OF HUSBAND OR WIFE <u>Dont know, divorced</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Very poor Hosp. records</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Advanced age and</u> DUE TO (c) <u>Generalized arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death. <u>manic depressive psychosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>154 1/2</u> <u>4221</u>	
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)			
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 <u>4-22-1949</u> to <u>10-8-1949</u> , that I last saw the deceased alive on <u>10-7-1949</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M. J. Muller M.D.</u>				23b. ADDRESS <u>State Hosp #1 - Fulton Mo 10-12-49</u>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>10-12-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>anatomical road</u>		24d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>	
DATE REC'D BY LOCAL REG. <u>Oct 12-1949</u>		REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. O. Roberts</u>		ADDRESS	

RECEIVED
OCT 18 1949
District Health Officer No. 9,
District File Number

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.