

FILED OCT 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33348

BIRTH NO. _____ REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 4221 Registrar's No. 78

1. PLACE OF DEATH a. COUNTY Holt		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Holt	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mound City	c. LENGTH OF STAY (in this place) 44 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mound City	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) James Harrison Combs			4. DATE OF DEATH (Month) (Day) (Year) Oct. 18, 1950		
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH April 28, 1906	9. AGE (In years last birthday) 44	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	IF UNDER 4 HRS. Hours	IF UNDER 4 HRS. Min.
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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) Mound City, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James Combs	13b. MOTHER'S MAIDEN NAME Ada Lovell	14. NAME OF HUSBAND OR WIFE
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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. 493-18-0432	17. INFORMANT'S SIGNATURE OR NAME Mrs. Roy Travis, Mound City, Mo.	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 17 months
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 10/18/50	19b. MAJOR FINDINGS OF OPERATION of injury	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Sept 15, 1950, to Oct 18, 1950, that I last saw the deceased alive on Oct 17, 1950, and that death occurred at 2 a. m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) M.D.	23b. ADDRESS Mound City, Mo.	23c. DATE SIGNED 10-19-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/20/50	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope cemetery	24d. LOCATION (City, town, or county) (State) Mound City, Mo.
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DATE REC'D BY LOCAL REG. 10-20-50	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Mound City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0440

0440



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. 1824

P. O. Address Mound City, 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.