

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29549**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **134**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Scott</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>	
b. CITY OR TOWN <b>Sikeston</b> (If outside corporate limits, write RURAL and give township)		c. CITY OR TOWN <b>Sikeston</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>16 Days</b>		e. STREET ADDRESS (If rural, give location) <b>201 N. West St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hospital</b>			

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Nancy</b> b. (Middle) <b>Leona</b> c. (Last) <b>Hobbs</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>8 2 1956</b>		
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>3-10-1893</b>	<b>9. AGE</b> (In years last birthday) <b>63</b>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>
<b>10a.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>0</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Scott Co., Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>

<b>13a. FATHER'S NAME</b> <b>Charles Matthews</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Fannie Malone</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ules Hobbs</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>0</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Ules Hobbs, Sikeston, Mo.</b>	
				<b>ADDRESS</b>	

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>18 days</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Cerebral Hemorrhage</b>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUE TO (b)</b> _____ <b>DUE TO (c)</b> _____		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>1. Hypertension, Cardiovascular Disease</b> <b>2. Hemiplegia, Partial</b>		<b>19. DATE OF OPERATION</b> <b>331X</b>	

<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	

**22. I hereby certify that I attended the deceased from 18 July, 1956, to Aug 2, 1956, that I last saw the deceased alive on Aug 2, 1956, and that death occurred at 11:20 p.m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <i>Andrew B. Smith, M.D.</i>		<b>23b. ADDRESS</b> <b>Sikeston, Mo.</b>		<b>23c. DATE SIGNED</b> <b>8-3-56</b>	
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<b>24a. BURIAL, CREMATION REMOVAL</b> (Specify) <b>BURIAL</b>		<b>24b. DATE</b> <b>8-5-56</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>MEMORIAL PARK</b>		<b>24d. LOCATION</b> (City, town, or county) (State) <b>SIKESTON MO</b>	
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<b>DATE REC'D BY LOCAL REG.</b> <b>8-13-56</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mr. [Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Welch Funeral Home - Sikeston Mo.</i>		<b>ADDRESS</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

1270

DATE RECEIVED AUG 20 1956

SCOTT CO. HEALTH DEPT.

CO. FILE No. 856-174

FEB 9 1957

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond J. Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.