V.S. No. 200
Rev. 10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32904

State File No.

FILED OCT 5 1956

BIRTH NO. REG. DIST. NO. 354 PRIMARY REG. DIST. NO 4519 Registrar's No. 87

1. PLACE OF DEATH
a. COUNTY: TEXAS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CABOOL
c. LENGTH OF STAY (in this place): 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DR. HOGG HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO. b. COUNTY: WRIGHT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): MTN. GROVE MO.
d. STREET ADDRESS (If rural, give location): 1140

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN b. (Middle): W. c. (Last): COMSTOCK

4. DATE OF DEATH (Month) (Day) (Year): OCT. 1 1956

5. SEX: M **6. COLOR OR RACE**: W **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): MARRIED

8. DATE OF BIRTH: MAY 21, 1893 **9. AGE** (In years last birthday): 63 If under 1 year: Months 4 Days 10 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: SAME
11. BIRTHPLACE (City and State or Foreign Country): EUREKA SPRINGS ARK.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: CHARLES COMSTOCK
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: ANNIE COBLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W. W. I
16. SOCIAL SECURITY NO.: 500-16-7594
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Annie Comstock **ADDRESS**: Mtn. Grove Mo.

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

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
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1, 1956, *to* _____, 19____, *that I last saw the deceased alive on* Oct 1, 1956, *and that death occurred at* 11 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Garnett Hogg M.D.
23b. ADDRESS: Cabool Mo
23c. DATE SIGNED: Oct 3 1956

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: Oct. 3/1956
24c. NAME OF CEMETERY OR CREMATORY: PENNER
24d. LOCATION (City, town, or county) (State): DOUGLAS COUNTY MO.

DATE REC'D BY LOCAL REG.: 10-4-56
REGISTRAR'S SIGNATURE: Gaynell Cunningham
25. FUNERAL DIRECTOR'S SIGNATURE: Rev Barber **ADDRESS**: Mtn. Grove

(Licensed Embalmer's Statement on Reverse Side)

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OCT 17 1956

OCT 17 1956

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.....

Licensed Embalmer No. 3844-R

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.