

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038040

STATE FILE NUMBER

17  
FILED NOV 10 1958

Registration District No. ....

318

Primary Registration District No. ....

1003

Registrar's No. ....

10189

5. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>ST LOUIS CITY HOSP #1</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>2618 No. 21 St. St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EMMETT</u> Middle Last <u>MOBLEY</u>		4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>58</u>	
5. SEX <u>Male</u> <input type="checkbox"/> <u>Female</u> <input type="checkbox"/>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1874</u>
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Rector, Arkansas. /</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Edna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> <u>Nil.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Lottie Willyard, 2618 N. 21st, St.</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastro intestinal hemorrhage</u> DUE TO (b) <u>bleeding duodenal ulcer</u> DUE TO (c) <u>congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Statin post operative subtotal gastrectomy</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>541.0</u>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>10/2/58</u> , to <u>10/22/58</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>10/22/58</u> Death occurred at <u>8:15</u> <u>P</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Carl Williams, M.D.</u> (Degree or title)		22b. ADDRESS <u>1515 LAFAYETTE</u>	22c. DATE SIGNED <u>10-23-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-23-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	23d. LOCATION (City, town, or county) (State) <u>Rector, Arkansas.</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe 4700 Washington, Blvd.</u> ADDRESS		25. DATE REGD. BY LOCAL REG. <u>OCT 24 58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>

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 *Robert M. Murray*

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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.