Health, & Welfare Public Service

9

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004964
STATE FILE NUMBER

FILED MAR 3 1959 Registration District No. 93 Primary Registration District No. _____ Registrar's No. 59-14

300
1-57

1. PLACE OF DEATH a. COUNTY Dade	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Dade
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Lockwood, Mo. Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Lockwood, Mo. 0 2 93 c. Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Memorial Hospital Length of stay in 1b 2 days	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First James	Middle William	Last Dobbs	4. DATE OF DEATH Month Feb. Day 7, Year 1959	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]	8. DATE OF BIRTH Oct. 9, 1871	9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months 3 Day 28 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Unknown 9	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Clair Easson; Address Lockwood, Mo.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Fractured left Femur and Shock

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senility

DUE TO (c) 90.49 .32

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 2-2-1959, to 2-5-1959 and last saw ~~her~~ him alive on 2-5-1959

Death occurred at 7:00 p.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE T. D. Combs (Degree or title) M.D. 0	22b. ADDRESS Lockwood, Mo.	22c. DATE SIGNED 2-8-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb.10,1959	23c. NAME OF CEMETERY OR CREMATORY Fordland
23d. LOCATION (City, town, or county) Fordland, Mo. (State)		
24. FUNERAL DIRECTOR W. R. Allison ADDRESS Greenfield, Mo.	25. DATE RECD. BY LOCAL REG. 2/16/1959	26. REGISTRAR'S SIGNATURE J. C. Canada

(Licensed Embalmer's Statement on Reverse Side)

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

T. D. Combs, M.D.

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 L. W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenville

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.