

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024367

FILED VS AUG 4 1959

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 198

DED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>	Length of stay in 1b <u>3 Yrs</u>	c. CITY OR TOWN <u>Fulton</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1217 Monroe</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1217 Monroe</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Ellen</u> Last <u>Hobbs</u>	4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1959</u>
--	--

5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1893</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
------------------	----------------------------	---	-----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	11. BIRTHPLACE (City and state or country) <u>Steedman Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	--	---

13a. FATHER'S NAME <u>Z.J. Rose</u>	13b. MOTHER'S MAIDEN NAME <u>Amelia K. Nehr</u>	14. NAME OF HUSBAND OR WIFE <u>Rev. O B. Hobbs</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>	16. SOCIAL SECURITY NO. <u>497-03-6371</u>	17. INFORMANT <u>O. B. Hobbs</u> Address <u>Fulton Mo.</u>
--	--	---

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>Cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Toxemia Carcinoma widely metastatic</u>	<u>9 months</u>
	DUE TO (c) <u>Carcinoma sigmoid colon, rapid growing type</u>	<u>12-18 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
--	---	--

20c. TIME OF INJURY: Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>March 1955</u> to <u>July 25, 1959</u> and last saw her alive on <u>July 24, 1959</u> Death occurred at <u>7:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>E. R. [Signature]</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Fulton Mo</u>	22c. DATE SIGNED <u>7/27/59</u>
---	-------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 27, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton Mo.</u>
---	--------------------------------	---	---

24. FUNERAL DIRECTOR <u>Maupin Funera l Home</u> ADDRESS <u>Fulton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>July 27, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS AUG 2 1959

VS AUG 2 0 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed J. C. Ross

Licensed Embalmer No. 2555

P. O. Address Fullerton

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.