

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 3 1959

59-024742

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2006 Registrar's No. 799

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo'</b> b. COUNTY <b>Greene</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>6</b> byrs	c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1125 Sherman St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1125 Sherman St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GENEVA</b> Middle <b>V</b> Last <b>COBB</b>			4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 9 94</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	11. BIRTHPLACE (City and state or country) <b>Springfield Mo'</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Lonnie Vickers</b>		13b. MOTHER'S MAIDEN NAME <b>Malinda McGoin</b>		14. NAME OF HUSBAND OR WIFE <b>E. F. Cobb</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Dr. E. F. Cobb 1125 Sherman St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia Myelogenous Chronic</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 year 11</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last.		DUE TO (b)				
		DUE TO (c)				
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input checked="" 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 a.m. p.m.	Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 <b>7-26-59</b> to <b>7-26-59</b> and last saw <sup>her</sup> him alive on <b>7-26-59</b> Death occurred at <b>7:30 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>J. Newton Wakerman MD</b> (Degree or title)			22b. ADDRESS <b>Springfield Mo</b>		22c. DATE SIGNED <b>7-28-59</b>	
23a. FUNERAL, CREMATION, RE-BURIAL (Specify)	23b. DATE <b>July 30-59</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Haziewood Cem'</b>		23d. LOCATION (City, town, or county) <b>Springfield</b>		(State) <b>Mo</b>
24. FUNERAL DIRECTOR <b>H. V. Smith 602 N Jerrerson St.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>7-30-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 19 1964

**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 Herbert V. Smith

Licensed Embalmer No. 4280

P. O. Address Spring

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.