MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 2 1959

59-031353
STATE FILE NUMBER

Registration District No. 002 Primary Registration District No. 5019 Registrar's No. 54

1. PLACE OF DEATH
a. COUNTY: ANDREW
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ROCHESTER TOWNSHIP
Length of stay in 1b:
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 1 mile S of Rochester
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: IOWA b. COUNTY: HAMILTON
c. CITY OR TOWN: WEBSTER CITY
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 511½ Second Street
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ABRAM Middle GISH Last COBLE
4. DATE OF DEATH: Month Sept. Day 19 Year 1959
5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12/9/95
9. AGE (last birthday): 63
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Lancaster Co., Penn.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Abram B. Coble
13b. MOTHER'S MAIDEN NAME: Laura E. Gish
14. NAME OF HUSBAND OR WIFE: - - - - -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 481-38-2445
17. INFORMANT: Address: Stewart Lund, Webster City, Iowa

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): Carbon monoxide poisoning.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Automobile exhaust.
DUE TO (c):
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☒ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Attached garden hose to tail-pipe of automobile, inserted into car.
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year Sept. 19 '59
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.): Farm
20f. CITY, TOWN, OR LOCATION: Rochester township COUNTY: Andrew STATE: Mo.

21. I attended the deceased from _____, to _____ and last saw him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Geo. Maxwell, D.O., Coroner (Degree or title)
22b. ADDRESS: 307 W. Main, Savannah, Mo.
22c. DATE SIGNED: 9/21/59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: Sept. 21, 59
23c. NAME OF CEMETERY OR CREMATORY: Mt. Tunnel Cemetery
23d. LOCATION (City, town, or county) (State): Elizabethtown, Penn.

24. FUNERAL DIRECTOR: Breit Funeral Home, Savannah ADDRESS
25. DATE RECD. BY LOCAL REG.: 9-23-59
26. REGISTRAR'S SIGNATURE: Lillian Sparks

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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

OCT 6 1959