

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031715

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau, County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Cape</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hendles</u>			Length of stay in 1b <u>62 Years</u>		c. CITY OR TOWN <u>Hendles</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>Hendles</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>Cleveland</u> Last <u>Hobley</u>				4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>M</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>5-8-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>20</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>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Indianapolis Ind</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Hobley</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy J. Meede</u>			14. NAME OF HUSBAND OR WIFE <u>Mrs Ida Hobley</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>490-05-0619</u>		17. INFORMANT <u>Mrs Ida Hobley</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>age and hardening of</u> DUE TO (c) <u>arteries.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)						INTERVAL BETWEEN ONSET AND DEATH <u>a few hours</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 10 months <input type="checkbox"/> Yes <input 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 _____ 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 <u>March 10 1959</u> to <u>August 26 1959</u> and saw him alive on <u>Aug 26 - '59</u> Death occurred at <u>Aug 26 - 59 - 530A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>W. S. Davieck</u> (Degree or title)				22b. ADDRESS <u>Delta Mo</u>		22c. DATE SIGNED <u>Sept 9 - 59</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-23-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Friends Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Oran, Mo</u>	
24. FUNERAL DIRECTOR <u>Shelley Funeral Home - Bell City Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>9-14-59</u>		26. REGISTRAR'S SIGNATURE <u>Gene Kasten</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Raymond L. Duffer

Licensed Embalmer No. 4798

P. O. Address Bonnie; T

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.