URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAY 6 1960

60-016972

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4452

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND, ST. LOUIS, MO.
Length of stay in 1b: 32 HRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS. ADMIN. HOSPT.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI
b. COUNTY Cole
c. CITY OR TOWN JEFFERSON CITY
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 117A DUNKLIN
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First FRANCIS Middle (NMI) Last JOBE
4. DATE OF DEATH: Month APRIL Day 22 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4/7/88
9. AGE (last birthday): 72
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): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): ELSTON, MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: MEPHY JOBE
13b. MOTHER'S MAIDEN NAME: NANCY PEEPER
14. NAME OF HUSBAND OR WIFE: MARGARET JOBE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 490-09-4972
17. INFORMANT: MARGARET JOBE
Address: 117A DUNKLIN JEFFERSON CITY, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CEREBRAL ANOXIA	12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	PROLONGED HYPOTENSION	12 hours
DUE TO (c)	MYOCARDIAL INFARCTION 420.1	12 hours

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.)
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. VA attended the deceased from 4/21/60, to 4/22/60 and last saw him alive on 4/22/60
Death occurred at 7:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): HUGH M. FOSTER JR. M.D.
22b. ADDRESS: VAH, ST. LOUIS, MO.
22c. DATE SIGNED: 4/23/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 4-23-60
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Jefferson City, Mo.
24. FUNERAL DIRECTOR ADDRESS: Thorpe Gordon Funeral Home, Jefferson City, Mo.
25. DATE REC'D. BY LOCAL REG.: APR 26 1960
26. REGISTRAR'S SIGNATURE: Karl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

US MAY 6 - 1960

US JUN 27 1960

MAY 13 1960

MAY 12 1960

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 Robert M. Murra

Licensed Embalmer No. 3749

P. O. Address St Louis

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