

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025532

FILED VS JUL 5 1960

Registration District No. 36-1 Primary Registration District No. 4515 Registrar's No. 55

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Sullivan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Sullivan			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Milan		Length of stay in lb 4 days		c. CITY OR TOWN Green City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION S C Memorial Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) No street address			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last David Jackson Mobley				4. DATE OF DEATH Month Day Year June 27, 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-5-1878	9. AGE (last birthday) 81	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) Farmer		10b. KIND OF BUSINESS OR INDUSTRY General farming		11. BIRTHPLACE (City and state or country) Brown's Co., Indiana		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Lewis Mobley			13b. MOTHER'S MAIDEN NAME Anna Stogdill		14. NAME OF HUSBAND OR WIFE Talitha J. Mobley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Talitha Mobley, Green City, Mo.		
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>Gastric Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
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 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>6-23-60</u> to <u>6-27-60</u> and last saw him alive on <u>6-27-60</u> Death occurred at <u>5:10</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>V.S. Robinson D.O.</u>				22b. ADDRESS <u>Milan, Mo</u>		22c. DATE SIGNED <u>6-28-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cenetry</u>		23d. LOCATION (City, town, or county) (State) <u>Adair County, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Glen E. Kent & Son, Green City, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>6-30-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Bessett</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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Carl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City.

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.