

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031273

1960 AUG 29 1960

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 5693 Registrar's No. 156

1. PLACE OF DEATH a. COUNTY <b>LIVINGSTON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>LIVINGSTON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>BLUE MOUND TWP.</b>		Length of stay in 1b <b>8 yrs.</b>		c. CITY OR TOWN <b>BLUE MOUND TWP.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1 Mi. N. BlueMound</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1 Mi. N. of BLUE MOUND</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>LEE</b> Last <b>COBB</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</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>4/6/1896</b>	9. AGE (last birthday) <b>64</b>	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) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and state or country) <b>CHILLICOTHE, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>NATHAN COBB</b>			13b. MOTHER'S MAIDEN NAME <b>CLARETTA RYUN</b>		14. NAME OF HUSBAND OR WIFE <b>ETHEL WEIDENHAMMER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>490-10-4738</b>		17. INFORMANT Address <b>LEE ROY COBB: MARCELINE, MISSOURI</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach with metastases</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 months</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) <b>Dehydration and malnutrition</b>					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 <b>July 1957</b> to <b>Aug 15, 1960</b> and last saw him alive on <b>Aug 14, 1960</b> Death occurred at <b>9:05 P.m.</b> on the date stated above, and to the best of my knowledge from the causes stated.							
22a. SIGNATURE (Degree or title) <b>William L. Fair, M.D.</b>			22b. ADDRESS <b>Chillicothe, Mo</b>			22c. DATE SIGNED <b>9/17/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8/18/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESTHAVEN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CHILLICOTHE, MISSOURI</b>			
24. FUNERAL DIRECTOR ADDRESS <b>NORMAN FUNERAL HOME: CHILLICOTHE, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>Aug 17, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Annalee Taylor</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS AUG 29 1968

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Elton F. Norman*

Licensed Embalmer No. 4036

P. O. Address Chillicothe,

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