42

APR 28 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8468

File No.

Registered No. 6

1. PLACE OF DEATH

County Henry — Registration District No. 347

Township — Primary Registration District No. 3018

City Clinton (No. ..... St. ..... Ward)

2. FULL NAME Charles Nelson Hobson

(a) Residence. No. 921 (Usual place of abode) South main St., ... Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M.	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 8 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
			3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Clinton Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER John Hobson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Henry Co Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Thelma Dettl

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Henry Co Mo
(STATE OR COUNTRY)

14. INFORMANT John Hobson
(Address) Clinton Mo

15. FILED ....., 19..... REGISTRAR

Walker

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 10 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-10, 19 30, to 3-10, 19 30, that I last saw h... alive on 3-10, 19 30, and that death occurred, on the date stated above, at 12 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

Influenza 2 days

CONTRIBUTORY (SECONDARY) Acute Dilatation of Heart (duration) 2 days yrs. ..... mos. ..... ds.

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED —

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? —

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) E. E. Walker, M. D.

3-11, 19 30 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calhoun, Mo	3/11 1930
20. UNDERTAKER	ADDRESS
Hobson & Son	Clinton Mo.

B—Every item
NURSE OF DEAT

carefully supp

PHYSICIAN should e
CCUPATION is very importa

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Henry Registration District No. 347 File No.
Township Clinton Primary Registration District No. 2018 Registered No.
City Clinton (No. St. Ward)

2. FULL NAME Charles Nelson Dobson

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 3/17, 1930 Dr. E.C. Peelor M.C. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/10 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19.....
that I last saw h... alive on ....., 19....., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration)...yrs. ...mos....ds.

CONTRIBUTORY (SECONDARY)
.....(duration)...yrs. ...mos....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed), M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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