

No. 2
4-12-40
5-17-39
X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21576**

Registration District No. **25-8**

Primary Registration District No. **5361**

Registrar's No. **5**

32
00
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County **DE KALB**

(b) City or town **RURAL SHERMAN TWP.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
7 mi North of Charksdale
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community **51 YEARS**
years, months or days

3. (a) PRINT FULL NAME **ARCH COBBINS**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **BEHE LEWIS**

6. (c) Age of husband or wife if alive **51 years**

7. Birth date of deceased **MAY 10-1887**
(Month) (Day) (Year)

8. AGE: Years **56** Months **1** Days **14**
If less than one day

9. Birthplace **CHARKSDALE MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business _____

MOTHER FATHER { 12. Name **SMITH COBBINS**

13. Birthplace **INDIANA**
(City, town, or county) (State or foreign country)

14. Maiden name **MARY JANE BARTRETT**

15. Birthplace **CHARKSDALE MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Warren Collins**

(b) Address **Charksdale mo**

17. (a) **Burial** (b) Date thereof **6-26-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Charksdale mo**

18. (a) Signature of funeral director **John P. Brown**

(b) Address **Charksdale mo**

19. (a) **JUNE-26-1941** (b) **Mrs. C. M. Davis**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **DE KALB**

(c) City or town **CHARKSDALE, RURAL SHERMAN TWP.**
(If outside city or town limits, write "RURAL")

(d) Street No. **R.F.D #1 CHARKSDALE**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? **NATIVE BORN** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **24**
year **1941** hour **8** minute **30** A. M.

21. I hereby certify that I attended the deceased from **VIEWED THE Body JUNE 24, 1941;**
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **CHRONIC MYOCARDITIS**

Due to _____

Due to _____

Other conditions **g3A**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **NONE**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **NONE**

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **232**

While at work? **232** (Specify type of place)

(e) Means of injury _____

23. Signature **William E. Rockwell** (M.D. or other) **Do**

Address **Union Star Mo.** Date signed **6/24/41**

Duration **5 yrs.**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 ML

....., Registered Apprentice No.

working under my personal supervision.

Signed John G. Brown

Licensed Embalmer No. 3933

P. O. Address Clarksdale, Miss.

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 this body is not embalmed, fact should be so stated above.