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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 22 1949

State File No. 31468

BIRTH NO.		REG. DIST. NO. 298		PRIMARY REG. DIST. NO. 6024		Registrar's No. 21			
1. PLACE OF DEATH a. COUNTY <i>Ray</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>Ray</i>					
b. CITY OR TOWN <i>Edmirstal</i>		c. LENGTH OF STAY (in this place) <i>3 yrs</i>		c. CITY OR TOWN <i>Edmirstal</i>		89			
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>---</i>				d. STREET ADDRESS (If rural, give location) <i>---</i>					
3. NAME OF DECEASED (Type or Print) <i>LEMUEL C. SCOBEE</i>			a. (First) <i>LEMUEL</i>			b. (Middle) <i>C.</i>			
c. (Last) <i>SCOBEE</i>			4. DATE OF DEATH <i>SEPT 4 1949</i>			5. SEX <i>Male</i>			
6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>July 30, 1875</i>		9. AGE (In years last birthday) <i>74</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mining</i>		11. BIRTHPLACE (State or foreign country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>			
13a. FATHER'S NAME <i>Robert Scobee</i>			13b. MOTHER'S MAIDEN NAME <i>Sarah Sizemore</i>			14. NAME OF HUSBAND OR WIFE <i>Frances Scobee</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>481-03-5617</i>		17. INFORMANT'S SIGNATURE OR NAME <i>Carl Scobee, Edmirstal, Mo.</i>				ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) <i>Myocardial exhaustion</i>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>Lobar pneumonia</i> DUE TO (c) <i>Hypertension, Hemiplegia</i>  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <i>left side</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 days</i> <i>490X</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <i>4-3-1949</i> , to <i>9-3-1949</i> , that I last saw the deceased alive on <i>9-3-1949</i> , and that death occurred at <i>9:50 p.m.</i> , from the causes and on the date stated above.									
23a. SIGNATURE <i>H. Wilkins, M.D.</i>				23b. ADDRESS <i>Paola, Mo.</i>			23c. DATE SIGNED <i>9-6-49</i>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>Sept 5, 1949</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Edmirstal</i>		24d. LOCATION (City, town, or county) (State) <i>Missouri City, Iowa</i>			
DATE REC'D BY LOCAL REG. <i>Sept 5, 1949</i>		REGISTRAR'S SIGNATURE <i>Mr. Raymond Howard</i>			364 25. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Lawson</i>		ADDRESS <i>Paola, Mo.</i>		

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 9-21-49

SEP 26 1949

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.

Signed Lindell K. Jarman

Signed.....  
Student Embalmer

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, Mo.

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.