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TEXAS DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1510 17

STATE OF TEXAS

CERTIFICATE OF DEATH

STATE FILE NO.

28421

1. PLACE OF DEATH a. COUNTY Galveston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Texas b. COUNTY Galveston	
b. CITY (If outside corporate limits, write RURAL and give precinct no.) Galveston		c. CITY (If outside corporate limits, write RURAL and give precinct no.) Galveston	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2602 Avenue O		d. STREET ADDRESS (If rural, give location) 2602 Avenue O	
3. NAME OF DECEASED (Type or Print) n. (First) Dr. Robert i. (Middle) Earl c. (Last) Cone		4. DATE OF DEATH May 24, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH February 27, 1894
9. AGE YEARS 61 MONTHS 2 DAYS 27		IF UNDER 24 HRS. Nil.	
10a. USUAL OCCUPATION (Other kind of work done during most of working life, even if retired) medical doctor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Galveston, Texas		12. FATHER'S NAME Edward O. Cone	
12. FATHER'S BIRTHPLACE		13. MOTHER'S MAIDEN NAME Maudie West	
13. MOTHER'S BIRTHPLACE		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	
15. SOCIAL SECURITY NO.		16. INFORMANT'S SIGNATURE Mrs. Mollie Parten Cone	
17. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Adenocarcinoma of the stomach			INTERVAL BETWEEN ONSET AND DEATH undetermined
ANTECEDENT CAUSES Asterisked conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
18a. DATE OF OPERATION March 25, 1954		18b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of the stomach	
19. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TEXAS DEPARTMENT OF HEALTH REC'D JUN 30 1955 BUREAU OF VITAL STATISTICS	
20a. ACCIDENT SUICIDE HOMICIDE (Specify)	20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20c. CITY, TOWN, OR PRECINCT NO. (COUNTY)	(STATE)
20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. HOW DID INJURY OCCUR	
21. I hereby certify that I attended the deceased from March 1, 1955 , to May 24, 1955 , that I last saw the deceased alive on May 24, 1955 , and that death occurred at 2:42 a.m. , from the causes and on the date stated above.			
22a. SIGNATURE Charles A. Hoobler, M.D.		22b. ADDRESS Johns Hopkins Hospital, Galveston, Tex	
22c. DATE SIGNED		23. NAME OF CEMETERY OR CREMATORY Galveston Memorial Park	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/25/55	
23c. LOCATION (City, town, or county) (State) Ditcherock, Texas		24. FUNERAL DIRECTOR'S SIGNATURE Joseph Levy	
25a. REGISTRAR'S FILE NO. 531		25b. DATE REC'D BY LOCAL REGISTRAR May 25, 1955	
25c. REGISTRAR'S SIGNATURE Magray		25d. REGISTRAR'S NO. 1268	

NOTE THE INFORMATION CALLED FOR ON THE REVERSE SIDE