PLACE OF DEATH

County Andrain

Township Cuerse

or

Village

or

City (NO. St.; Ward)

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

Registration District No. 72/244

Primary Registration District No. 4-5-57 2046

File No. 27003

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Romine Hubbell

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

DATE OF BIRTH: July (Month) 14 (Day), 1916 (Year)

AGE: yrs. mos. ds.

If LESS than 1 day 36 hrs. or min.?

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

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

BIRTHPLACE (City or town, State or foreign country): Andrain Co

PARENTS

NAME OF FATHER: C A Hubbell

BIRTHPLACE OF FATHER (City or town, State or foreign country): Indiana

MAIDEN NAME OF MOTHER: Susie Romine

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C A Hubbell

(ADDRESS) Fisher Mo

Filed Aug 1, 1916. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 15 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from July 14, 1916, to July 15, 1916, that I last saw him alive on July 15, 1916, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis

79A

(Duration) yrs. 36 hrs mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) W K McGeall M. D.

7-15-1916 (Address) Laddonia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Laddonia Mo

DATE OF BURIAL: 7-16-1916

UNDERTAKER: H G Grainger

ADDRESS: Laddonia Mo.

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____ _____ St.; _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____, 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
- NAME OF FATHER _____
- BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
- MAIDEN NAME OF MOTHER _____
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____ _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, 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.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS