WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Audrain

Township Cuivre

or

Village ~~Laddonia Mo.~~

or

City _____ (NO. _____ St.; _____ Ward)

Registration District No. ~~24~~ 912

Primary Registration District No. ~~6232~~

File No. 30357

Registered No. 21

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

FULL NAME Wm Thomas Hibbert

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: March (Month) 18 (Day), 1852 (Year)

AGE: 64 yrs. 5 mos. 1 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

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

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

BIRTHPLACE (City or town, State or foreign country): Bates Co. Mo.

PARENTS

NAME OF FATHER: Geo Hibbert

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

MAIDEN NAME OF MOTHER: Ann Hayes

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wm T Hibbert

(ADDRESS) Laddonia Mo.

Filed Sept 11, 1916. W W Bland REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug (Month) 19 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from April 1, 1916, to Aug 19, 1916, that I last saw him alive on Aug 18, 1916, and that death occurred, on the date stated above, at 8:10 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 2 yrs. 40 mos. ___ ds.

Contributory (SECONDARY) Hernia

(Duration) 23 yrs. ___ mos. ___ ds.

(Signed) W. K. McCall M. D.

Aug 21, 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. 5 mos. ___ ds. In the State 64 yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? State Mo

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Cuivre Church

DATE OF BURIAL: Aug 21 1916

UNDERTAKER: H G Granger

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

_____, *1*_____
(Month) (Day) (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

_____, *191*____
(Month) (Day) (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

under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

For persons who have no occupation whatever write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection [illegible] time and causation), using always the