

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

Do not use this space. **72**

1. PLACE OF DEATH

County Barry Registration District No. 29
Township Flaterick Primary Registration District No. 5038
City Cassville (No. _____) St. _____ Ward _____

2. FULL NAME Thomas A. Heubert

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M.</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 10 1871</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>59</u>	<u>1</u>	<u>4</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer 1</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Barry Co Mo

13. NAME Wm Heubert

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Barry Co Mo

15. MAIDEN NAME Narella Jones

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss 2

17. INFORMANT (ADDRESS) Mrs. Thos. Heubert Cassville

18. BURIAL, CREMATION, OR REMOVAL
PLACE Cassville DATE Jan 15 1931

19. UNDERTAKER (ADDRESS) Harine Felt Service Cassville Mo

20. FILED Mar 1 1931 Mrs. H. R. Williams
Spt Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 2 1930 to Jan 12 1931

22. I HEREBY CERTIFY, That I attended deceased from Nov 2 1930 to Jan 12 1931
I last saw him alive on Jan 12 1931 Death is said to have occurred on the date stated above, at 11:50 p.m.
The principal cause of death and related causes of importance were as follows:

Chronic Nephritis

Date of onset

Other contributory causes of importance:

Ulcer of Stomach

Name of operation _____ Date of _____

What test confirmed diagnosis Drugs Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____ (1)

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Herm H. Zuber, M. D.

(Address) Cassville Mo

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.

2.3 1931

**MISSOURI STATE BOARD OF HEALTH
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1-31
ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Barr Registration District No. 29 File No. _____
 Township Flat Creek Primary Registration District No. 5038 Registered No. 2
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Thomas A. Hembest

(a) Residence, No. _____ St. _____ Ward _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT _____
 (Address)

15.

FILED May 31 1931 Mrs. N. R. Williams REGISTRAR
Spit

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1931

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
 _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY: _____

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) _____, M. D.

, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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