

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.

70
7
6

120
1
2
1

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

Do not use this space.

FEB 27 1935

2171

1. PLACE OF DEATH

County MONTGOMERY
Township _____
City WELLSVILLE (No. _____, _____ St. _____ Ward)

Registration District No. 595
Primary Registration District No. 4353

File No. 1
Registered No. 1

2. FULL NAME REECE HUGHES

(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 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>MALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>MARRIED</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>MAMIE HUGHES</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>FEB - 15 - 1854</u>		
7. AGE YEARS <u>80</u>	MONTHS <u>10</u>	DAYS <u>22</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>RETAIL DEALER IN FERMENTED LIQUOR</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>(RETIRED)</u>		
10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 7, 1935

22. I HEREBY CERTIFY That I attended deceased from Jan 1, 1935 to Jan 7, 1935

I last saw him alive on Jan 5, 1935. Death is said to have occurred on the date stated above, at 12:20 pm.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset 1/7/35

Other contributory causes of importance: Arteriosclerosis ?

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

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

If so, specify _____

(Signed) D. G. Dyer M. D.

(Address) Wellsville, Mo.

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>CALLAWAY CO. MO.</u>
	13. NAME <u>ARMESTED HUGHES</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>VIRGINIA</u>
	15. MAIDEN NAME <u>MARY BOONE HAYS</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>MISSOURI</u>
17. INFORMANT <u>MAMIE HUGHES</u> (ADDRESS) <u>WELLSVILLE MO</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>WELLSVILLE MO</u> DATE <u>JAN - 9</u> 19 <u>35</u>	
19. UNDERTAKER <u>F. W. KUHN</u> (ADDRESS) <u>WELLSVILLE MO</u>	
20. FILED <u>Jan 9, 1935</u> Mrs. Mike Waffernutt Registrar.	

