

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.

AUG 22 1935

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

Do not use this space.

25284

1. PLACE OF DEATH

County Scott

Registration District No. 821

File No. \_\_\_\_\_

Township Subston

Primary Registration District No. 4553

Registered No. \_\_\_\_\_

City \_\_\_\_\_ (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

2. FULL NAME Orlie May-Hibler

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Ward \_\_\_\_\_

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

yrs.

mos.

ds.

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

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Blk

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14 1931

7. AGE YEARS MONTHS DAYS

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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) Subston Mo

FATHER 13. NAME Quittie Hibler

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss

MOTHER

15. MAIDEN NAME Hadie B. Moham

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid Mo

17. INFORMANT (ADDRESS) Quittie Hibler  
Cornthorville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE New Madrid Mo DATE 7/23/35

19. UNDERTAKER (ADDRESS) J. H. Deerpote  
Subston Mo

20. FILED Aug 6 1935 W. H. Presnell  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 9 2 1935

22. I HEREBY CERTIFY, That I attended deceased from July 21 1935, to July 22 1935

I last saw her alive on July 21 1935. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Lobar Pneumonia

Date of onset July 20 35

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? clinical

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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Howard M. Kelly, M. D.

(Address) Subston Mo

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

ALL INFORMATION CALLED  
FOR MUST NOT BE TAKEN ON  
THIS SUPPLEMENTARY,

**1. PLACE OF DEATH**

County Scott  
Township \_\_\_\_\_  
City Sikeston (No. \_\_\_\_\_)

Registration District No. 821  
Primary Registration District No. 4583

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Pessie May Hibler

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14, 1935

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 8

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
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) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19. \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 9-5 1935 Russ Orsullo Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 22, 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows: \_\_\_\_\_  
Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_  
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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Howard M. Kendrick M. D.  
(Address) Sikeston

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.

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