

REC'D MAY 18 1938

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

14628
Do not use this space.

1. PLACE OF DEATH
 (a) County Madison Registration District No. 316
 (b) Township _____ Primary Registration District No. 2001 Registered No. 319
 (c) City Springfield mo (d) Street No. Burge Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Margaret Hubbard
 (a) Residence, No. _____ St. Carthage Mo
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. J. Hubbard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10 - 1894

7. AGE YEARS 44 MONTHS 2 DAYS 3 If LESS than 1 day, hrs. or min. 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House duty
 9. Industry or business in which work was done, as 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) Illinois

FATHER 13. NAME J. C. Deen
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

MOTHER 15. MAIDEN NAME Alice Boatright
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) A. J. Hubbard Carthage Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest PK DATE 4/15 - 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hurlbut Ind. Co Great. Mo.

20. FILED Apr 15 1938 Chas. A. George Local Registrar 290

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4 - 13 - 1938

22. I HEREBY CERTIFY, That I attended deceased from April 13, 1938, to Apr 13, 1938
 I last saw her alive on Apr 13, 1938 Death is said to have occurred on the date stated above, at 9 P m.
 The principal cause of death and related causes of importance were as follows:

	Date of onset
<u>Uterine Myoma</u>	<u>1930</u>
<u>Rt femoral Thrombo-phlebitis</u>	<u>1937</u>
<u>Pulmonary Embolism</u>	<u>Apr 13 1938</u>

Other contributory causes of importance: Hysterectomy

Name of operation Hysterectomy Date of Apr 11, 1938
 What test confirmed diagnosis? _____ 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 _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify no
 (Signed) Fred R. Forthing, M. D.
 (Address) Med Arts Bldg Springfield, Mo

54 B

MAY 2 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____
_____, or by _____
Registered Apprentice No. _____, working under my personal supervision.

Signed

Steve Parker

Licensed Embalmer No. *2548*

P. O. Address *Joplin Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

14628
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001 Registered No. _____
 (c) City Springfield (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Margarett Hubbard

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)

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.
44 2 3

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-13, 1938

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

uterine myoma of fibroid character
uterine fibroid (not malignant)
Pulmonary Embolism

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) Fred R. Farthing, M. D.
 (Address) mdn apt. Bldg Springfield mo

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

SUPPLEMENT

Handwritten text, possibly a signature or name, located in the lower-left quadrant of the page. The text is illegible due to the high contrast and noise of the scan.