

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.

REC'D JAN 13 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 9

41973
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 1002
 (b) Township Jaw Primary Registration District No. _____ Registered No. 5029
 (c) City Jackson City (d) Street No. North East 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

(a) Residence, No. 4123 So. Benton 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 Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John O. Hughes
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 24 1853
 7. AGE YEARS 83 MONTHS 3 DAYS 1 LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION
 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. at home
 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) Rochester NY

FATHER
 13. NAME Chas. Condon

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

MOTHER
 15. MAIDEN NAME Sarah Christy

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

17. INFORMANT (ADDRESS) Ed Hughes 4123 So. Benton

18. BURIAL, CREMATION, OR REMOVAL PLACE Carthage Mo. DATE Dec 27 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) D. W. Newcomer's Sons Brushcreek & Paseo

20. FILED 12-27-38 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 25 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct 20 1938 to Dec 25 1938
 I last saw her alive on Dec 25 1938. Death is said to have occurred on the date stated above, at 2:55 P.
 The principal cause of death and related causes of importance were as follows:

Gangrene Right Foot. Date of onset _____
 Other contributory causes of importance: Chronic Endarteritis & Arteriosclerosis

Name of operation no Date of _____
 What test confirmed diagnosis? John's 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) Dr. Frank Gray M. D.
 (Address) 4316 E 9th, K.C. Mo.

Be 0162
3 P.M.

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..... *Neil Carr*

Licensed Embalmer No..... *3976*

P. O. Address.....

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.