

K. 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.

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

44358  
 Do not use this space.

RECEIVED JAN 10 1939

**1. PLACE OF DEATH**  
 (a) County St. Clair 2 Registration District No. 761  
 (b) Township M. Morgan Primary Registration District No. 6014 Registered No. 20  
 or Appleton City (c) City (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** SARAH JANE HUGHES  
 (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 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 FRANKLIN HUGHES

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 2 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>72</u>	<u>10</u>	<u>20</u>	

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

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) Camden Mo. O

**FATHER**  
 13. NAME Jacob Bouserman  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Camden Mo. O

**MOTHER**  
 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Camden Mo. O

17. INFORMANT (ADDRESS) Mary Ann Sands  
Appleton City Mo. R. 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Richmond Mo DATE Dec. 25 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Oscar Eckhoff  
Appleton City Mo.

20. FILED Dec 25 1938 Clis Abney  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 22 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 22 1938 to Dec 22 1938  
 I ~~last~~ did not see her alive 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:  
Cause not known.

Other contributory causes of importance: Appt

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) R. L. Hansen, M. D.  
Appleton City Mo. (Address)

RECEIVED

District Health Officer No. 7,

District File Number 7-38-593

Date Filed 12-31-38

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**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 Oscar E. Hoff

Licensed Embalmer No. 3942

P. O. Address Appleton City

**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.**