

REC'D FEB 11 1939

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

4187
Do not use this space.

1. PLACE OF DEATH

- (a) County Wenonah Registration District No. 875
 (b) Township Center Primary Registration District No. 3039 Registered No. 315
 (c) City Neosho (d) Street No. Wenoda 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. 135 Leo Hibdon St. _____
Statsbury Missouri
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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 Ruth Hibdon

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 3 1912

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
26 3 28

- OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Comm Robber
 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) Dec 27 1938
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Waverly Mo O

- FATHER 13. NAME Wiram Hibdon S

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

- MOTHER 15. MAIDEN NAME Josie Allen

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

17. INFORMANT (ADDRESS) Mrs Ruth Hibdon
Statsbury Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Versailles Mo DATE Jan 3 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ferry Funeral Home
Neosho Mo

20. FILED Jan 1 1939 Allen Vidaris Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1939

22. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at 4:40 p.m.

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

Skull Fracture at base of brain Date of onset Jan 1 1939

Other contributory causes of importance:
Auto Truck, Over Street Concrete bridge

Name of operation none Date of _____

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 Accident Date of injury _____

Where did injury occur? Neosho Mo Highway # 71
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Highway

Nature of injury Skull Fracture

24. Was disease or injury in any way related to occupation of deceased?

If so, specify not on map

(Signed) M. E. Ferry Coroner

(Address) 775

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
BUREAU OF HEALTH SERVICES

RECEIVED
District Health Officer No. 7
District File Number 7-39238
Date Filed 2-9-39

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, Personal

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed

Lloyd B. Wimsatt

Licensed Embalmer No. 3857

P. O. Address Merced, Ca

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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Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875

(b) Township Nevada Primary Registration District No. 3039

(c) City Nevada (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 Leo Hibdon

(a) Residence, No. _____ St.

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 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.
	<u>26</u>	<u>3</u>	<u>m</u>	

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)

FATHER

13. NAME Hiram Richard Hibdon

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

MOTHER

15. MAIDEN NAME Jessie Allen

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1-1 1939 Allen V. Hays Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-1, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h_____ 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) M. E. Ferry Coast

(Address) _____ Mo

THIS FORM CANNOT BE RECEIVED UNTIL IT IS COMPLETED AS PRESCRIBED BY LAW. It is the duty of every citizen to properly classify and state occupation as prescribed by law.

SUPPLEMENTAL

S-4187