

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

43418
 Do not use this space.

1. PLACE OF DEATH: *GREENE* Registration District No. *318*
 (a) County
 (b) Township *SPRINGFIELD* Primary Registration District No. *2001*
 (c) City (d) Street No. *Springfield Baptist Hospital* Registered No. *953*
 (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 *120 Chestnut L. Tubbs*
 (a) Residence, No. *120 Chestnut L. Tubbs* St. (If nonresident, give city or town and State)
 (b) Residence, No. *120 Chestnut L. Tubbs* St. (If nonresident, give city or town and State)
 (c) Residence, No. *120 Chestnut L. Tubbs* St. (If nonresident, give city or town and State)
 (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 *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mrs. Minnie Tubbs*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 13, 1877*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
62 11 19

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

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) *Barton Co Missouri*

FATHER 13. NAME *Wilber Tubbs*

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

MOTHER 15. MAIDEN NAME *Minnie Montgomery*

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

17. INFORMANT (ADDRESS) *Dean Tubbs*
Bullings, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Theresa* DATE *Jan 2, 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. S. Wallace*
Bullings, Mo.

20. FILED *1/2/40* N. *Chas. A. George M.D.* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec. 31, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *12:27, 1939, to 12:21, 1939*
 I last saw him alive on *12-28, 1939*. Death is said to have occurred on the date stated above, at *8:10 A.M.*
 The principal cause of death and related causes of importance were as follows:
Deep pneumonia following suppurative otitis media
 Other contributory causes of importance: *✓ 127 W*

Name of operation *Cole's extirpation* Date of *12-27-39*
 What test confirmed diagnosis? *gale stones for presbycusis* 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) *E. P. Rockberg*, M. D.
 (Address) *Springfield*

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.

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,

Everett R. Head

, or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Everett R. Head

Licensed Embalmer No. *4038*

P. O. Address *Billings, 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.

X

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

43418
Do not use this space.

1. PLACE OF DEATH *Greene* Registration District No. *318*
 (a) County *Greene* Primary Registration District No. *209* Registered No. *953*
 (b) Township *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 *Arthur L. (unk) Jubb*
 (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 *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.
62 11 19

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.
 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

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED *3/1/61* *1960* *Chas. A. George* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 31 1957*

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) *E. J. Roehrig*, M. D.

(Address) *Springfield Mo*

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE FILED AND REGISTERED IN ACCORDANCE WITH THE LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary if important.

