

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

3951

Registration District No.

Primary Registration District No.

Registrar's No.

FILED FEB 15 1940

6039

8

1. PLACE OF DEATH:

(a) County Saline Co.
(b) City or town County Home Near Marshall Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Months
(Specify whether
In this community
years, months or days)

3. (a) PRINT

FULL NAME Wilhelmina Johanna Kummell Hustedde

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex Female

5. Color or

race White

6. (a) Single, widowed, married,

divorced Widowed

6. (b) Name of husband or wife William

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased Jan. 31, 1856.

(Month)

(Day)

(Year)

8. AGE:

Years

Months

* Days

If less than one day

83

11

5

hr. _____ min.

9. Birthplace Union Missouri

(City, town, or county)

(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

12. Name Henry Krummell

13. Birthplace Germany

(City, town, or county)

(State or foreign country)

14. Maiden name Don't know

15. Birthplace Germany

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature Mrs. Clark Turner

(b) Address Gilliam Mo.

17. (a) Burial (b) Date thereof Jan. 8, 1940.

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation Near Glasgow Mo.

18. (a) Signature of funeral director Salzer

(b) Address Slater Mo.

19. (a) 1-8-40 (b) Mary Kent

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Gilliam
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan., 6, 1940
year _____ hour 3 minute _____ M.

21. I hereby certify that I attended the deceased from August
month, 1929, to Dec 30, 1939
that I last saw her alive on Dec 30, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma face & neck

Duration

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Where it occurred (Specify type of place)
(e) Means of injury

23. Signature Mary Kent (M. D. or other)

Address Marshall Mo. Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

58

RECEIVED
District Health Officer No. 8,
District File Number 44140
Date Filed

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.....

Licensed Embalmer No. 1831

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.

**MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

3957

Registration District No. 796

Primary Registration District No. 6039

Registrar's No.

8

1. PLACE OF DEATH:

- (a) County Saline
 (b) City or town Marshall Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution (Specify whether

In this community
years, months or days)**3. (a) PRINT FULL NAME**Wilhelmina Johanna Kummell Huster

- (b) If veteran,
-
- name war

- (c) Social Security
-
- No.

4. Sex

7

5. Color or

race w

6. (a) Single, widowed, married,

divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if

alive

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

83

11

5

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

- (b) Address

17. (a)

(Burial, cremation, or removal)

- (b) Date thereof

(Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a)

(Date received local registrar)

- (b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County

- (c) City or town

(If outside city or town limits write "RURAL")

- (d) Street No.

(If rural, give location)

- (e) If foreign born, how long in U. S. A.?

years.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Month Janday 6year 1940

hour

minute

M.

21. I hereby certify that I attended the deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma face and neck

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

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Of operations

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Duration

PHYSICIAN

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- (a) Accident, suicide, or homicide (specify)

- (b) Date of occurrence

- (c) Where did injury occur?

(City or town)

(County)

(State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

R.C. Haynes

(M. D. or other)

Address

Marshall tw

Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

