

RUB MAR 5 1940

Registration District No. _____ Primary Registration District No. 5744

1. PLACE OF DEATH:
 (a) County Marion
 (b) City or town Round Grove
 (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 2
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Marion
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Round Grove Sup.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME James Hurst 623
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced 1
 6. (b) Name of husband or wife See Anna Hurst 6. (c) Age of husband or wife if alive 5-6 years
 7. Birth date of deceased April 4 - 1873
 (Month) (Day) (Year)

8. AGE: Years 66 Months 9 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Taylor, Mo. (City, town, or county) (State or foreign country)
 10. Usual occupation Farmer

11. Industry or business _____
 12. Name Albert Hurst
 13. Birthplace Ky. (City, town, or county) (State or foreign country)
 14. Maiden name Rebecca Coon
 15. Birthplace Palmyra, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Virgil Meyer
 (b) Address Durham, Missouri
 17. (a) Rural (b) Date thereof Jan 20
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Durham, Mo
 18. (a) Signature of funeral director Thomas Ball
 (b) Address Living, Mo. 401
 19. (a) Jan 27, 40 (b) J.M. Crebs
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 18th
 year 1940 hour 10 minute 15-P M.
 21. I hereby certify that I attended the deceased from at time
a wife - fatal attack, Jan 18 - 1940
 that I last saw him alive on News Law until Jan 18th, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure
 Due to Coronary occlusion
with duration of few hours
 Other conditions none
 (Include pregnancy within 3 months of death)
 Major findings: Of operations none
 Of autopsy none
 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) none
 (b) Date of occurrence none
 (c) Where did injury occur? none
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
none
 (Specify type of place)
 While at work? none (e) Means of injury none
 23. Signature James Hurst (M. D. or other) 3
 Address Living, Mo Date signed 1-19-40

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should 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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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

State File No. 7377
Registrar's No. 1

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. 037

Primary Registration District No. 5744

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

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Leslie Ins
(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.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME James Hurst
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 66 Months 9 Days 14 If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....
19. (a) Filed Jan 27, '48 (Date received local registrar) J. M. Crebs (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 Jan day 18 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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?.....

While at work..... (Specify type of place) (e) Means of injury.....

23. Signature Guy W. Cable (M. D. or other).....
Address Leslie Ins Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

