

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

APR 23 1940

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

12253
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Francis Registration District No. 1115
 (b) Township St. Joseph Primary Registration District No. 6021 Registered No. 8
 (c) City Knobloch (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 Robert Allen Hibbitts
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth M. Hibbitts

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 8 - 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>84</u>		<u>1</u>	<u>17</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. Farmer
 10. Date deceased last worked at this occupation (month and year) one year 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Knobloch

FATHER
 13. NAME William Hibbitts
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. S. A.

MOTHER
 15. MAIDEN NAME Martha Jacobs
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. S. A.

17. INFORMANT (ADDRESS) J. Hibbitts

18. BURIAL, CREMATION, OR REMOVAL PLACE Knobloch Mo DATE 3/27/40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Farmington and Co. Farmington Mo.

20. FILED 3-26 1940 H. L. Byrnes Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 25 1940

22. I HEREBY CERTIFY, That I attended deceased from Dec 26 1939 to Mar 20 1940
 I last saw him alive on March 4 1940 Death is said to have occurred on the date stated above, at 11:15 a.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral apoplexy
(2nd stroke) @ 72 H.
 Date of onset 1st Dec 26 1939

Other contributory causes of importance:
arteriosclerosis, myocarditis

Name of operation _____ 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? _____ 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? no
 If so, specify _____
 (Signed) L. M. Stanfield, M. D.
 (Address) Farmington Mo.

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.

1 X1402B

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, me

or by _____

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

Signed Mellie Harter

Licensed Embalmer No. 2969

P. O. Address Farmington, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12253

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1115

Primary Registration District No. 6021

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Lecky
(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 _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) City or town St. Francois
(c) City or town Knob Lick
(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.

3. (a) PRINT FULL NAME

Robert A. Hibbits

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 wid

6. (b) Name of husband or wife Elizabeth Hibbits

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

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years 84 Months 1 Days 17

If less than one year _____ min.

9. Birthplace

(City, town, or county) (State or foreign country)

MOTHER FATHER

11. Industry or business HIBBITS

12. Name Wm Hibbits

13. Birthplace (City, town, or county) Tenn.

(State or foreign country)

14: Maiden name

15. Birthplace (City, town, or county) Ky.

(State or foreign country)

16. (a) Informant

(b) Address

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-15-40 (b) F. G. Rydeen

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 25
year 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 _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

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? _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature L. N. Stanfield (M. D. or other) _____
Address Warrenton Date signed _____

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

SUPPLEMENTAL

1940
S-12253