

MAY 13 1940

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

14454

Do not use this space.

1. PLACE OF DEATH

(a) County Caldwell, Registration District No. 93
(b) Township Fairview, 2 Primary Registration District No. 5139 Registered No. 7
(c) City or (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. 36 (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

John Franklin Hibner,
(a) Residence, No. Caldwell Co 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 Male 4. COLOR OR RACE White 5. Married (write the word)
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct.-8th., -1878
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
61 6 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer.
9. Industry or business in which work was done, as saw mill, bank, etc. Farming.
10. Date deceased last worked at this occupation (month and year) April-10th-1940 11. Total time (years) spent in this occupation. 50

12. BIRTHPLACE (CITY OR TOWN) Caldwell County,
(STATE OR COUNTRY) Missouri.

13. NAME Nichlos Hibner,
14. BIRTHPLACE (CITY OR TOWN) Not Known,
(STATE OR COUNTRY) Caldwell County,

15. MAIDEN NAME Elizabeth Waters,
16. BIRTHPLACE (CITY OR TOWN) Missouri.
(STATE OR COUNTRY)

17. INFORMANT Mrs. Bertha Hibner
(ADDRESS) Braymer, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE White Cemetery April-21st. 1940

19. FUNERAL DIRECTOR (NAME) F. P. Michael
(ADDRESS) Braymer, Mo.

20. FILED Apr 21 1940 H. H. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 20 1940

22. I HEREBY CERTIFY, That I attended deceased from April 19 1940, to April 20 1940
I last saw him alive on April 20 1940. Death is said to have occurred on the date stated above, at 1:45 P.M.
The principal cause of death and related causes of importance were as follows:

Hyperstatic Pneumonia Date of onset 4-19-40

Other contributory causes of importance:

Primary Anemia Chronic Bronchitis unknown 1934

Name of operation none Date of
What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no 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 none
Nature of injury

24. Was disease or injury in any way related to occupation? no
If so, specify

(Signed) John R. Crank M. D.
(Address) Braymer, Mo.

1058

STATE

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 E. P. Michael
Licensed Embalmer No. 1363
P. O. Address Braymer, 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. 17454

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 93

Primary Registration District No. 5139

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Farmview T. P.
(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 John Franklin

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 m

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 61 Months 6 Days 12 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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 apr day 20 year 1990 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 Septicemic Pneumonia Lobar Duration _____

Due to _____

Due to _____

Other conditions Primary Anemia
(Include pregnancy within 3 months of death)
chr. Bronchitis

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? _____

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

23. Signature John P. Crane M.D. (Other) _____

Address Raymer _____ Date signed _____

SUPPLEMENTAL

S-14454