

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.

MAY 20 1940

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

15785

Do not use this space.

1. PLACE OF DEATH *Phelps 2*  
 (a) County..... *Phelps* Registration District No. *677*  
 (b) Township..... ~~Rolla~~ Primary Registration District No. *4403*  
 (c) City..... *Rolla* (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 *Andrew Humbinger*  
 (a) Residence, No. *Second and Pine* 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. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Alice Stinson Humbinger*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 22, 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*74 6 29*

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

9. Industry or business in which work was done, as saw mill, bank, etc. *Trucking*

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) *Greensburg Ind*

FATHER 13. NAME *Tobias Humbinger*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany.*

MOTHER 15. MAIDEN NAME *Elizabeth Rader*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany.*

17. INFORMANT *Mrs. Elizabeth Graham*  
 (ADDRESS) *Rolla Mo*

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE *Rolla* DATE *4/23* 1940

19. FUNERAL DIRECTOR (NAME) *Mrs. Harry McCaw*  
 (ADDRESS) *Rolla Mo.*

20. FILED *April 23* 1940 *Joe F. Myers* Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4/21* 1940

22. I HEREBY CERTIFY, That I attended deceased from *4-1* 1940 to *4-21* 1940  
 I last saw him alive on *4-20* 1940 Death is said to have occurred on the date stated above, at *4:30 a. m.*  
 The principal cause of death and related causes of importance were as follows:  
*Senility*  
*Malnutrition*  
*Senile Demetia*

Date of onset *1/6/38*

Other contributory causes of importance:  
*6*

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) *E. E. Feind* M. D.  
*6/11* (Address) *Rolla, Mo.*

**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.~~

District Health Officer No. 6,

District File Number 540 589

Date Filed 5-17-40

Signed.....

*R. J. McCaw*

Licensed Embalmer No. 3953

P. O. Address Rolla

**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.**