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SEP 16 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

28547

State File No. 707

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

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

1. PLACE OF DEATH:  
(a) County Kreme  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 19 days (Specify whether  
In this community 19 days years, months or days)

3. (a) PRINT FULL NAME RUTH OLIVE HEBB 100

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 15 1911  
(Month) (Day) (Year)

8. AGE: Years 29 Months 0 Days 13 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Evangelist Singer

11. Industry or business Churches

12. Name George Hebb

13. Birthplace Howard Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Alma Wells

15. Birthplace Unknown Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Leah Hebb

(b) Address Howard Kansas

17. (a) Burial (b) Date thereof Aug 31 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Howard Kansas

18. (a) Signature of funeral director F. L. Thomas  
(b) Address Springfield Mo

19. (a) Aug 31 1940 (b) W. E. Dudley M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Kansas (b) County \_\_\_\_\_  
(c) City or town Howard  
(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 August day 28  
year 1940 hour 6:20 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Aug 9, 1940, to Aug 28, 1940, that I last saw him per alive on Aug 28, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction Duration 19 days

Due to Previous Operative Adhesions 3 yrs.

Due to Left Surgical Prosthesis 9 days

Other conditions Left Surgical Prosthesis (Include pregnancy within 3 months of death)

Major findings: Adherent bands strangulating ileum. Of operations \_\_\_\_\_ Of autopsy None

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? At home

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

23. Signature Howard K. Haller (M. D. or other) \_\_\_\_\_  
Address 500 Holland Bldg Date signed 8/29/40

**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 Fred C. Thomas

Licensed Embalmer No. 2899

P. O. Address Springfield, 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.**

