

17-39
I X21492

Registration District No. 871

Primary Registration District No. 6155

Registrar's No. 14

1. PLACE OF DEATH

(a) County Vernon
(b) City or town (Rural) Orags township
(c) Name of hospital or institution:
Orags township
(d) Length of stay: In hospital or institution 71 yrs.
In this community 71 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon
(c) City or town Rural
(d) Street No. Orags township
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME Margaret Elizabeth Humble

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Charles Humble 6. (c) Age of husband or wife if deceased Deceased

7. Birth date of deceased Nov 20 1940

8. AGE: Years 99 Months 8 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Hancock Co Ill

10. Usual occupation Housewife

11. Industry or business Home

12. Name Adam Lewis Rose

13. Birthplace Unknown Ill

14. Maiden name America Jane Wilson

15. Birthplace Unknown Ill

16. (a) Informant Mary Thomas

(b) Address Holt, Mo.

17. (a) Burial (b) Date thereof 9/2/40

(c) Place: burial or cremation Baltown Cemetery

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Nevada, Mo.

19. (a) _____ (b) _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21, year 1940 hour 11 minute 30 A M.

21. I hereby certify that I attended the deceased from about 1930 to July 31 1940 that I last saw her alive on July 10 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to ✓
Due to ✓
Other conditions none

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature W. Love (M.D. or other) _____
Address Nevada, Mo. Date signed Aug 5/40

Duration ✓
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1301

Date Filed 9-11-40

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 Person

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Lloyd R. Winsett

Licensed Embalmer No. 3857

P. O. Address Yewade, 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. **19974**
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **871**

Primary Registration District No. **6153**

1. PLACE OF DEATH:

(a) County **Vernon**
(b) City or town **Orange Twp.**
(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

3. (a) PRINT FULL NAME

Margaret Elizabeth Humble

(b) If veteran, name war _____

3. Social Security No. _____

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years **99**

Months **8**

Days **11**

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) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **8-10-40**

(Date received local registrar)

(b) **J Helma Wilson**

(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

19. DATE OF DEATH CERTIFICATION

20. DATE OF DEATH: Month **July** day **31**
year _____ ho _____ 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 **M. S. Long** (M. D. or other) _____

Address **Meranda mo** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL COPY

