

Registration District No. **143**

Primary Registration District No. **5205**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Center
 (b) City or town Van Buren
 (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 5 years (Specify whether
 In this community _____ years, months or days)

8. (a) PRINT FULL NAME JOHN OSCAR TUBBS
 8. (b) If veteran, name war no
 8. (c) Social Security No. no

4. Sex M
 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Betty
 6. (c) Age of husband or wife if alive 37 years
 7. Birth date of deceased Oct 6 (Month) (Day) (Year)

8. AGE: Years 50 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Ellington Mo (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Labor

12. Name Glenn Tubbs

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

14. Maiden name Martha Barnes

15. Birthplace Ellington Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
 (b) Address _____

17. (a) Quiria (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation Ellington, Mo

18. (a) Signature of funeral director Crash - Leavelle

(b) Address Van Buren, Mo

19. (a) 9-28-40 (b) Mo
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Center
 (c) City or town Van Buren (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 Sept day 27 year 1940 hour _____ minute 5:45 PM.
 21. I hereby certify that I attended the deceased from May 7th 1935 to Sept 27th 1940
 that I last saw him alive on September 27th 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritic
calculi in urinary
passages,
urinary abscess
 Duration 10 yrs?
 Due to _____
 Due to 3/1

Other conditions (include pregnancy within 3 months of death) J. M. Callahan, D.

Major findings: Of operations _____
 Of autopsy _____
 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? 35
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature McKellan (M. D. or other) _____
 Address Van Buren Date signed 9-19

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.

RECEIVED

District Health Officer No. 5,

District File Number 1040874

Date Filed _____

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 J. Allen Davis

Licensed Embalmer No. 4053

P. O. Address Van Buren

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. 31667

Registration District No. 143

Primary Registration District No. 5205-

Registrar's No.

1. PLACE OF DEATH:

(a) County Carter
(b) ~~City or town~~ Carter 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.....
In this community..... (Specify whether
years, months or days)

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.

3. (a) PRINT FULL NAME

John Oscar Tubbs

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..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 50 Months 11 Days 21 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 Van Buren, Mo

19. (a) 9-28-70 (b) J. W. Cotto
(Date received local registrar) (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 27
year 1970 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.....

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 T. H. Cotton (M. D. or other).....

Address Van Buren Missouri

SUPPLEMENTAL

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

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

