

FILED OCT 23 1940

STANDARD CERTIFICATE OF DEATH

State File No. 31892

Registration District No. 1035

Primary Registration District No. 5372

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Dent  
(b) City or town Rural Texas Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
XX  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
0  
In this community all her life  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent  
Rural Texas Typ.  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. XX  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month sep<sup>2</sup> day Sept.  
year 1940 hour 11 minute 00A.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.

3. (a) PRINT FULL NAME Mary E Hubbs  
3. (b) If veteran, name war XX 3. (c) Social Security No. X

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife John Hubbs 6. (c) Age of husband or wife if alive 83 years  
7. Birth date of deceased Aug 8 1867  
(Month) (Day) (Year)

Immediate cause of death Pneumonia (Fibrous) ✓ 2 days  
Duration

8. AGE: Years 72 Months 11 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Asthma  
Due to \_\_\_\_\_

9: Birthplace Dent Co Mo  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation housewife

Major findings: Of operations ✓  
Of autopsy ✓

11. Industry or business \_\_\_\_\_

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

12. Name William Courtian

18. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Stout

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

16. (a) Informant Jim Hubbs

(b) Address Salem Mo

17. (a) Burial (b) Date thereof 9/4/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Forest Cem

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address Salem Mo

19. (a) 9/4/40 (b) J. J. Jurek  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature J. J. Jurek (M. D. or other) \_\_\_\_\_  
Address Salem, Mo. Date signed 9/6/40

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

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**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.....

*Paul K. Jensen*

Licensed Embalmer No.....

09370

P. O. Address.....

*Salem*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **31892**

Registration District No. **1035-**

Primary Registration District No. **5372**

Registrar's No. **8**

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

1. PLACE OF DEATH:

(a) County **Dent**  
(b) City or town **Texas 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..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME **Mary E. Hubbs**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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 **72** Months **11** Days **6** If less than one day..... hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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) (Date received local registrar) (b) (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 **Sept** day **2** year **1940** 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 **Pneumonia**  
**Fibrinogen**

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

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..... (M. D. or other).....

Address..... Date signed.....

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 31892

Registration District No. 1035

Primary Registration District No. 5372

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County DeWitt  
(b) City or town Respart, 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) (Specify whether

3. (a) PRINT FULL NAME

Mary E. Hubbs

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

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 Aug 8 1864  
(Month) (Day) (Year)

8. AGE:

Years 73 Months 11 Days 24

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 9/4 (b) H. J. Kisack  
(Was 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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH \_\_\_\_\_ month Sept day 2  
year \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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) Means of injury \_\_\_\_\_

23. Signature S. G. Dillon (M. D. or other) \_\_\_\_\_  
Address Salem Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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