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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

35324

NOV 20 1940

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 841

1. PLACE OF DEATH  
 (a) County GREENE  
 (b) City or town Springfield  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: City Hospital  
 (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

3. (a) PRINT FULL NAME Robert Gene Hurtado

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

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

6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive 2 1/2 years

7. Birth date of deceased April 10, 1936  
(Month) (Day) (Year)

8. AGE:			If less than one day	
Years	Months	Days	hr.	min.
<u>1 1/4</u>	<u>6</u>	<u>3</u>		

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

10. Usual occupation Child

11. Industry or business Child

12. Name Chester Hurtado

13. Birthplace New Madrid Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Lula Belle Hubert

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

16. (a) Informant Chester Hurtado

(b) Address 1100 E. Pine, Ct.

17. (a) Burial (b) Date thereof 10-15-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Yeakley Cem

18. (a) Signature of funeral director Alma Kohmeyer  
(b) Address Springfield Mo

19. (a) 10-15-40 (b) W. E. Haudley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Greene  
 (c) City or town Springfield  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1100 E. Pine  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13, year 1940 hour 9 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from Oct 11<sup>th</sup>, 1940, to Oct 13, 1940, that I last saw him alive on Oct 13, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute Toxicemia  
Intestinal Obstruction Duration 2-3 days

Due to Obvulus (Stenosis) Duration 2-3 days

Due to \_\_\_\_\_  
Other conditions 12/13  
(Include pregnancy within 3 months of death)

Major findings: Collapsse of intestines  
 Of operations below (trans) Obvulus  
 Of autopsy None

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) No

(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? No

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

Signature J. Newton Workman (M. D. or other) \_\_\_\_\_  
Address Springfield Mo. Date signed 10-15-40

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

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

*Ed George*, Registered Apprentice No. *204*

working under my personal supervision.

Signed *E. O. Northey*

Licensed Embalmer No. *1767*

P. O. Address *Springfield*

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, fact should be so stated above.

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