

Registration District No. 608

Primary Registration District No. 6-807A

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Barry NEWTON  
 (b) City Stella Cassville, Missouri R.F.D.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Stella Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution About 2 weeks  
 (Specify whether  
 In this community All of life  
 years, months or days)

8. (a) PRINT FULL NAME

John L. Hankins

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

widowed

6. (b) Name of husband or wife

Martha Jane Hankins

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

Deed years

7. Birth date of deceased

Nov.  
(Month)

9  
(Day)

1865  
(Year)

8. AGE:

Years

Months

Days

If less than one day

75

9

7

hr. min.

9. Birthplace

Barry Co.

(City, town, or county)

Missouri

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

12. Name Samuel L. Hankins

13. Birthplace

(City, town, or county)

Tenn.

(State or foreign country)

14. Maiden name Celia Vineyard

15. Birthplace

(City, town, or county)

Tenn.

(State or foreign country)

16. (a) Informant

W. M. Hankins

(b) Address

Cassville, Missouri

17. (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept. 19. 40

(Month) (Day) (Year)

(c) Place: burial or cremation

Antioch

18. (a) Signature of funeral director

Horine & Culver

(b) Address

Cassville, Missouri

19. (a)

Oct. 26-40

(Date received local registrar)

(b) Ada Collings

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry  
 (c) City or town Cassville, Missouri R.F.D.  
 (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 16th  
 year 1940 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept 11, 1940 to Sept 16, 1940  
 that I last saw him alive on Sept 15, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death

Cirrhosis of the liver

Duration

26 M.

Due to

Due to

Fracture of hip

Other conditions

(include pregnancy within 3 months of death)

PHYSICIAN

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?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

O. Cardwell

(M. D. or other)

Address

Stella 9mo

Date signed

10/24/40

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

RECEIVED

District Health Officer No. 6,

District File Number 1140-2879

Date Filed NOV 15 1940

**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.....

*R. Gordon Bennett*

Registered Apprentice No. 200

working under my personal supervision.

Signed

*G. E. Colver*

Licensed Embalmer No. 3584

P. O. Address Cassville, N.C.

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **35927**

Registration District No. **608**

Primary Registration District No. **3807A**

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

1. PLACE OF DEATH

(a) County **Newton**  
(b) City or town **Stella**  
(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

**John L Hankins**

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 **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 **75** Months **9** Days **7**

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

(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) \_\_\_\_\_

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

(Date 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **9** day **16**  
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

**Inguina Pectoris**  
**Call at home of**  
**of a nurse.**  
**Fracture of Hip**

Major findings:

Of operations

Of autopsy

**2/2 m**  
**3/4**

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) \_\_\_\_\_ (c) Means of injury

23. Signature \_\_\_\_\_ (M. D. or other) **12/1/70**

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

