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

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1042

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kaw (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joseph Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community 12 Hrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 31
(c) City or town Kansas City Mo (If outside city or town limits, write "RURAL")
(d) Street No. Gallatin Mo (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Baby Hershberger
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 1 (Day) 1941 (Year)

8. AGE: Years | Months | Days | If less than one day 1 hr. min.

9. Birthplace Kansas City Mo (City, town, or county) 0 (State or foreign country)
10. Usual occupation None
11. Industry or business
MOTHER FATHER
12. Name Arbanis Lee Hershberger
13. Birthplace Petersburg (City, town, or county) Indiana 1 (State or foreign country)
14. Maiden name Addie Olive Cox
15. Birthplace Gallatin (City, town, or county) Missouri 0 (State or foreign country)
16. (a) Informant Mrs. A. L. Hershberger
(b) Address Gallatin, Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan (Month) 1 (Day) 1941 (Year)
(c) Place: burial or cremation Gallatin Mo
18. (a) Signature of funeral director Harry Hope
(b) Address Gallatin Mo
19. (a) 1-1-41 (Date received local registrar) (b) M M Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 1
year 1941 hour 12 minute 40 A 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.

	Duration
Immediate cause of death Congenital heart disease	1 hr
Due to	
Due to 157E	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Congenital heart disease

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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature [illegible] (M. D. or other)
Address St Joseph Hospital

(Licensed Embalmer's Statement

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.