

No. 2  
13-40  
17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **9923**

FILED APR 28 1941  
Registration District No. **26**

Primary Registration District No. **3002**

Registrar's No. **42**

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

1. PLACE OF DEATH:  
(a) County **Andrain Mo.**  
(b) City or town **Mexico Mo.**  
(c) Name of hospital or institution **Andrain Hospital**  
(d) Length of stay: In hospital or institution **4 days**  
In this community **2.5 years**

3. (a) PRINT FULL NAME **SUSAN AMANDA HUBBELL**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. **none**

4. Sex **female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **widow**  
6. (b) Name of husband or wife **C. A. Hubbell**  
6. (c) Age of husband or wife if alive **dead**  
7. Birth date of deceased **Jan 1 - 1897**

8. AGE: Years **64** Months **2** Days **6**  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace **Douglas Co. Ill**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business **home**

12. Name **G. F. Korvine**

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

14. Maiden name **Sarah Rice**

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

16. (a) Informant **Sarah Jane Nyeth**  
(b) Address **Garrett Ill**

17. (a) **burial** (b) Date thereof **3-9-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Laddonia Mo**  
18. (a) Signature of funeral director **H. H. Brainerd**  
(b) Address **Laddonia Mo**  
19. (a) **March 7 1941** (b) **Blanche Neely**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Andrain**  
(c) City or town **Laddonia**  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **March** day **7th.**  
year **1941** hour **3** minute **P.** M.

21. I hereby certify that I attended the deceased from **Feb. 25**, 19**41** to **March 7**, 19**41**, that I last saw her alive on **March 7**, 19**41**, and that death occurred on the date and hour stated above.

Immediate cause of death **Peritonitis**  
Duration **48 hrs**

Due to **Appendicial Abscess**

Due to **Following Influenza**

Other conditions \_\_\_\_\_

Major findings: **J. F. Jolley (Surgeon)**  
Of operations **Appendicial Abscess**

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 **W. K. McCall** (M. D. or other) **0**  
Address **Laddonia Mo** Date signed **3-8-41**

RECEIVED

District Health Officer No. 10

District File Number 4-41-768

Date Filed APR 14 1941

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.....

*H. G. Granger*

..... Registered Apprentice No. ....

working under my personal supervision.

Signed..... *H. G. Granger*

Licensed Embalmer No. *1297*

P. O. Address *Laddonia, Md.*

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.