No. 2
-10-39
7-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1941

Registration District No. 460

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4274

State File No. 31909

Registrar's No. 47

1. PLACE OF DEATH:
(a) County Lafayette Co
(b) City or town Higginsville
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County 54
(c) City or town 2
(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.? 0 years.

3. (a) PRINT FULL NAME Betty Lou Hoyner
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Sing 0
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased April 22 1941 (Month) (Day) (Year)

8. AGE: Years ____ Months 5 Days 6 If less than one day ____ hr. ____ min.

9. Birthplace Higginsville Mo (City, town, or county) (State or foreign country)
10. Usual occupation ____
11. Industry or business ____

FATHER
12. Name Ernest Hoyner
13. Birthplace Higginsville Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Clara Mae Bledsoe
15. Birthplace Higginsville Mo (City, town, or county) (State or foreign country)

16. (a) Informant Ernest Hoyner
(b) Address Higginsville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/41 (Month) (Day) (Year)
(c) Place: burial or cremation Bray Cemetery
18. (a) Signature of funeral director W. S. Hardy
(b) Address Higginsville Mo
19. (a) Oct 7-1941 (Date received local registrar) (b) T. Isaac Webb (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28 year 1941 hour 7 Found Dead minutes ____ M.

21. I hereby certify that I attended the deceased from Jan 1 1941 to Last seen alive 12-30-41 19____; that I last saw alive on 4-28-41 19____; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(a) Acute Bronchial Pneumonia	2 hrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Acute Bronchial Pneumonia	

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 no
(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 ____

23. Signature W. E. Martin M. D. (M. D. or other)
Address Lexington Mo Date signed Oct 2

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-13-41

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 Doris A Rickhof

Licensed Embalmer No. 3637

P. O. Address Higginsville Ky

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

If this body is not embalmed, above space should be left blank.

No. 2B
—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31909

Registration District No. 460 Primary Registration District No. 4274 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Higginsville
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette
(c) City or town Higginsville
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Betty L. Haynes

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

4. Sex F
5. Color or race B
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Apr. (Month) 22 (Day) 1941 (Year)

8. AGE: Years | Months 5 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Nov-8-1941 (Date received local registrar) (b) T. Harry Webb (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 28
year 1941 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 Acute Bronical pneumonia — Duration

Due to

Due to

Other conditions 107
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

1941
S-31909