

WILLIAMS DEC 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38791

Registration District No. 527

Primary Registration District No. 5703

Registrar's No.

1. PLACE OF DEATH:

- (a) County MACON
 (b) City or town BEVER
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution. (Specify other)

In this community 50 YEARS
years, months or days3. (a) PRINT FULL NAME BENJAMIN B. HUGHES

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

4. Sex M.A.L.E. 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife Nell Roberts
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased AUGUST 17 1865
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 2 5 - hr. - min

9. Birthplace COLUMBUS GROVE OHIO
(City, town, or county) (State or foreign country)10. Usual occupation FARMER11. Industry or business FARMING

- MOTHER FATHER
 12. Name DAVID HUGHES
 13. Birthplace 9
 (City, town, or county) (State or foreign country)
 14. Maiden name MARY BEST
 15. Birthplace 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ben Hughes
 (b) Address Bever, Mo.
 17. (a) BURIAL (b) Date thereof 11-25-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WEST OAK VA. CEMETERY18. (a) Signature of funeral director W. E. Colwell
(b) Address Bever, Mo.

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MISSOURI (b) County MACON
 (c) City or town BEVER "RURAL"
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 22
year 1941 hour 11 minutes 30 P.M.

21. I hereby certify that I attended the deceased from Sept 15, 1941, to Nov 22, 1941;
 that I last saw H.M. alive on Nov 21, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death

Bronchial pneumonia
Relational
 Due to Lowered resistance
 Due to abdominal tumor?

Duration

4 daysOther conditions
(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?

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

23. Signature E. S. Housinger (M. D. or other) MD
Address MACON MO. Date signed Dec 1, 1941

105-2 (Licensed Embalmer's Statement on Reverse Side)

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 *J. H. Edwards*

Licensed Embalmer No. *1961*

P. O. Address *Bowie, Md.*

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

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

STANDARD CERTIFICATE OF DEATH

State File No. 38791

Registration District No. 527

Primary Registration District No. 5703

Registrar's No.

1. PLACE OF DEATH:

- (a) County Marion
- (b) City or town Palmer
(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)

3. (a) PRINT FULL NAME Ben. B. Hughes

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.

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 76 Months 3 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.

MOTHER FATHER { 12. Name.

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

14. Maiden name.

15. Birthplace.
(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) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2
year 1941 hour. minute. M.

21. I hereby certify that I attended the deceased from 9 to 6 19...; that I last saw him alive on 9 19...; and that death occurred on the date and hour stated above.

Immediate cause of death.

Due to sub-dermal tumor
I cannot give the desired
information. This patient was
never X-rayed, operated on,
was an autopsy performed.
Other conditions I saw the patient late
in his illness and
believe the growth
was malignant but
cannot state so
definitely.
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: believe the growth was malignant but cannot state so definitely.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) 55e
- (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. (M. D. or other)

Address. Date signed.

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

SUPPLEMENTARY

S-38791