DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 7 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3991

Registration District No. 892 — Primary Registration District No. 6194 — Registrar's No. 11

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

1. PLACE OF DEATH:

(a) County WAYNE

(b) City or town Jaskee-Blooms Ferry (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 61 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County WAYNE

(c) City or town JASKEE (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 .....

3. (a) PRINT FULL NAME IONA CATTRON HUGHES

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife .....

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

7. Birth date of deceased APR (Month) 8 (Day) 1869 (Year)

8. AGE: Years 72 Months 8 Days 2 If less than one day ..... hr. ..... min.

9. Birthplace BLOOMFIELD (City, town, or county) ILL (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business .....

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

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

16. (a) Informant Ora O. Cattron

(b) Address Williamsville Mo R#2

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 14-1941 (Month) (Day) (Year)

(c) Place: burial or cremation CATTRON CEM

18. (a) Signature of funeral director N. T. Phelps

(b) Address Poplar Bluff Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 10 year 1941 hour 12 minute 14 P.M.

21. I hereby certify that I attended the deceased from Nov 15, 1941, to Dec 10, 1941; that I last saw her alive on Dec 10, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 weeks
Due to: Hypertension arteriosclerosis	?
Due to:	
Other conditions (Include pregnancy within 3 months of death)	430

Major findings:
Of operations none
Of autopsy none

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 A F Brookerson M.D. (M. D. or other)

Address Poplar Bluff Date signed 12-12-41

(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 N. T. Phelps

Licensed Embalmer No. 3231

P. O. Address Poplar Bluff Mo

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

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

. S. No. 2B
0M—8-21-41
I X29288

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3991

Registration District No. 892 Primary Registration District No. 6194 Registrar's No.

1. PLACE OF DEATH:
(a) County: Wayne
(b) City or town: Tatkee
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Dona C. Hughes
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Apr (Month) 8 (Day) 1869 (Year)
8. AGE: Years 72 Months 8 Days 22 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) (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) Dec. 11, 1941 (Date received local registrar) (b) Mrs. Lottie Manns (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 4 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	Duration
Due to	
Due to	
Other 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)
(b) 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