

FILED MAR 24 1940

Registration District No.

Primary Registration District No.

6188

Registrar's No.

1. PLACE OF DEATH:

(a) County Wayne
 (b) City or town St. Francis
 (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 _____
 In this community 81 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne
 (c) City or town St. Francis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6 miles W. Greenfield
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16
 year 1942 hour 3:30 minute 30 P.M.
 21. I hereby certify that I attended the deceased from Jan 15-42
 _____, 19____, to Jan 16-42, 19____;
 that I last saw her alive on Jan 15-42, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia Duration 7 days

Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) 108

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 Geo Flechner (M. D. or other) MD
 Address Greenfield, Mo Date signed 1-17-42

3. (a) PRINT FULL NAME Clementine 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 2

6. (b) Name of husband or wife Anderson Hughes 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. Dec. 9 1860
 (Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Missouri (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation Home Wife

11. Industry or business _____

12. Name John Melton

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

14. Maiden name Anderson

15. Birthplace 11 (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant Clayton Pearson

(b) Address Williamsville, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18 1942 (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Hill

18. (a) Signature of funeral director National Funeral Home

(b) Address Greenfield

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

1222 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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 *Wallace N. Fitch*
Licensed Embalmer No. *3859*
P. O. Address *Poplar Bluff, Mo.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8155
Registrar's No.

Registration District No. 896

Primary Registration District No. 6188

1. PLACE OF DEATH:

(a) County Wayne Rural
(b) City or town Wayne Rural
(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 Mo (b) County Wayne
(c) City or town Piedmont 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 _____

3. (a) PRINT FULL NAME Clementine 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 Dec 9 1909
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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) Jan 18-1942 (b) B. H. Bennett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 18 Year 1942 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I first saw him _____ 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)

(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

