

Registration District No. 796

Primary Registration District No. 6039

Registrar's No. 91

1. PLACE OF DEATH: **Saline**
 (a) County **Saline**
 (b) City or town **Rural**
 (c) Name of hospital or institution: **none**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **35 years**
 In this community **35 years**
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Ann Elizabeth Hume**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **none**

4. Sex **female**
 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Rob't. B. Hume**
 6. (c) Age of husband or wife if alive **82** years
 7. Birth date of deceased **August 26 1861**
 (Month) (Day) (Year)

8. AGE: Years **80** Months **9** Days **5**
 If less than one day hr. **0** min.

9. Birthplace **Florissant, St. Louis Co. Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business _____

MOTHER FATHER
 12. Name **Jos. L. Hyatt**
 18. Birthplace **Mo.**
 14. Maiden name **Elizabeth Harris**
 15. Birthplace **Mo.**

16. (a) Informant's own signature **Joe H. Hume**
 (b) Address **Slater, Mo.**

17. (a) **burial** (b) Date thereof **6-2-1942**
 (Burial, cremation, or other) (Month) (Day) (Year)
Marshall, Mo.
 (c) Place: burial or cremation

18. (a) Signature of funeral director **Hill Brothers**
 (b) Address **Slater, Mo.**

19. (a) **6-2-42** (b) **Mrs. O. Weeber**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Saline**
 (c) City or town **Rural**
 (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.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **31st**
 year **1942** hour **10** minute **8** M.

21. I hereby certify that I attended the deceased from **May 29**, 19**42** to **May 31**, 19**42**
 that I last saw her **er** alive on **May 30**, 19**42**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Bronchial pneumonia
 Due to **General arteriosclerosis**
 Due to _____

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

Major findings: _____
 Of operations _____
 Of autopsy _____

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 **Hill Brothers M.D.** (M. D. or other)
 Address **Marshall, Mo.** Date signed **6/1/42**

Duration
4 days
 PHYSICIAN
 Underline the cause to which death should be charged statistically

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

7
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-11-42

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 A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Slater, 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, above space should be left blank.