

Registration District No. \_\_\_\_\_

Primary Registration District No. **3000**

Registrar's No. **2164**

1. PLACE OF DEATH:

(a) County **Adair**  
(b) City or town **Rocksville Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **Brim-Smith 0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 month 4 days**  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Knox 52**  
(c) City or town **Edina 0**  
(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 **Effie Gay Glover**

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

4. Sex **F** 1 5. Color or race **W** 6. (a) Single, widowed, married, divorced **2**

6. (b) Name of husband or wife **deceased** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **August 14 1859**  
(Month) (Day) (Year)

8. AGE: Years **83** Months **1** Days **28** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Newark Mo. 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper**

11. Industry or business \_\_\_\_\_

12. Name **David Ringes**

13. Birthplace **Hagerstown Md. 1**  
(City, town, or county) (State or foreign country)

14. Maiden name **Maribel Dunning**

15. Birthplace **Louisville Ky.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ms Grace H Lee**

(b) Address **Edina Mo.**

17. (a) **Newark Mo** (b) Date thereof **Oct 14 1942**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Newark Cemetery**

18. (a) Signature of funeral director **Wm H. Regan**

(b) Address **Edina Mo.**

19. (a) **10/13/42** (b) **Mer H. Baynes**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **12** year **1942** hour **2** minute **30** M.

21. I hereby certify that I attended the deceased from **Sept 9** 1942 to **Oct 12** 1942 that I last saw him **alive** on **Oct 12** 1942 and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture of right femur**  
**att hep**

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) **accident**

(b) Date of occurrence **059**

(c) Where did injury occur? **Edina Knox Mo**  
(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 **W. H. Baynes** (M. D. or other \_\_\_\_\_)

Address **Edina Mo** Date signed **10/12/42**

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

66-1

RECEIVED  
District Health Officer No. 10  
District File Number 11-42-2025  
Date Filed NOV - 9 1942

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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Miss

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33044  
Registrar's No. 264

Registration District No. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:

- (a) County Adair
- (b) City or town Hubersville, Mo.  
(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 \_\_\_\_\_
- (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

Effie Gay Glover

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

Aug 14 1885  
(Month) (Day) (Year)

8. AGE:

83

Years

Months

Days

If less than one day \_\_\_\_\_ min.

9. Birthplace

Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

Mo.  
(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)

(Date received local registrar)

(b)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 12 Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture of right femur & hip Duration 6 weeks

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) accident
- (b) Date of occurrence about Aug 20<sup>th</sup>, 1942
- (c) Where did injury occur? Church Street Mo.  
(City or town) (County) (State)
- (d) Did injury occur in or about home, in industrial place, in public place?  
street

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury fall

23. Signature Robert M. D. or other Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

