

No. 2
5-42
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 7 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40439

Registration District No. 6

Primary Registration District No. 4090

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Carter
(b) City or town Rural - near Hunter
(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 whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carter
(c) City or town Near Hunter
(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 Nellie Grace Hubbs

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, Married

6. (b) Name of husband or wife J. W. Hubbs 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 22, 1894
(Month) (Day) (Year)

8. AGE: Years 48 Months 48 Days 6 If less than one day hr. 8 min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Jack Hall

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

14. Maiden name "

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

16. (a) Informant Keith Hubbs, Hunter, Mo.

(b) Address _____

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Advance, Mo.

18. (a) Signature of funeral director Greer Croy Funeral Serv.

(b) Address Poplar Bluff, Missouri

19. (a) Dec 31 (Data received local registrar) (b) ms A J Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30 year 1942 hour 5 minute _____ A. M.

21. I hereby certify that I attended the deceased from 12-28-42 to 12-30-42; that I last saw her alive on 12-28-42 and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia

Due to Hypertension
Due to nephritis

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 2

23. Signature Frank J. Reanski (M. D. or other) P.O.

Address Van Buren, Mo. Date signed 12-31-42

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No 5,

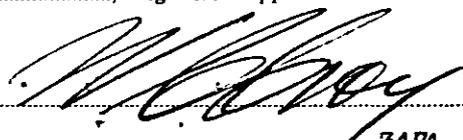
District File Number 14315.

Date Filed 1-6-43

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.....



Licensed Embalmer No. 3474

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.

STANDARD CERTIFICATE OF DEATH

State File No. 40439

Registration District No. 5

Primary Registration District No. 4090

Registrar's No.

1. PLACE OF DEATH:

(a) County Carter
(b) City or town 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 Carter
(c) City or town Rural
(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 Nellie G Hubbs

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 June 22 (Month) (Day) (Year)

8. AGE: Years 48 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 Jack Hall

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

14. Maiden name Hubbs

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 30 Year 1942 hour _____ M. _____
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Emphysema Duration 3de
Due to Hypertension
Due to Nephritis (chronic)

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

