

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 12 1943
Registration District No. 141

Primary Registration District No. 3020 5, 18, 51

Registrar's No. 54

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

1. PLACE OF DEATH:

(a) County Newton

(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: M.T.D.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 yrs (Specify whether years, months or days)

In this community 50 yrs

3. (a) PRINT FULL NAME Lucy Hull

3. (b) If veteran name war

3. (c) Social Security No. ✓

4. Sex 7 5. Color or race W 6. (a) Single, (widowed) married, divorced W

6. (b) Name of husband or wife S. M. Hull 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased 3-14-1856
(Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days 7 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER

12. Name Amos Flicker

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

14. Maiden name Olga

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

16. (a) Informant Robert Hull

(b) Address West Plains Mo

17. (a) (Burial, cremation, or removal) None (b) Date thereof 4/23-43
(Month) (Day) (Year)

(c) Place: burial or cremation None

18. (a) Signature of funeral director Robert Hull

(b) Address West Plains Mo

19. (a) 5-8-43 (b) Miss Hull
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell

(c) City or town R. F. D.
(If outside city or town limits, write "RURAL")

(d) Street No. West Plains
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 21 year 1943 hour 6 minute 20 A.M.

21. I hereby certify that I attended the deceased from January 15, 1943, to April 18, 1943;
that I last saw him alive on April 15, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure and senility

Due to Endocarditis and Auricular fibrillation

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 92

Of autopsy none

Duration

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 R. A. Sparks (M. D. or other)

Address West Plains Mo Date signed 4/29/43

RECEIVED

District Health Officer No 5

District File Number 643339

Filed 6. 7. 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 Paige L Roberts

Licensed Embalmer No. 3433

P. O. Address West Lane, S

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.