

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

MAILED AUG 1943  
Registration District No. 47

Primary Registration District No. 3008

State File No. \_\_\_\_\_  
Registrar's No. 209

1. PLACE OF DEATH

(a) County Callaway

(b) City or town Fulton  
(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 Missouri (b) County Callaway

(c) City or town Fulton  
(If outside city or town limits, write "RURAL.")

(d) Street No. 804 State  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) FULL NAME Miss Henrietta Kibby

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9  
year 1943 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 31  
1943, to July 9, 1943  
that I last saw her alive on July 9, 1943  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro

6. (a) Single 0 widowed 0 married 0  
divorced 0 Single

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Oct 6 1865  
(Month) (Day) (Year)

Immediate cause of death Sen arterio-sclerosis

Duration a few years

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>9</u>	<u>3</u>	hr. _____ min. _____

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Pyelitis  
(include pregnancy within 3 months of death)

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

10. Usual occupation Cook

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: 97

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

12. Name Henry Kibby

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

14. Maiden name Nancy Churchhill

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

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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. B. [unclear] (M. D. or other) \_\_\_\_\_

Address Fulton Mo Date signed 7/10/43

MOTHER FATHER

16. (a) Informant Lorena Kibby

(b) Address Fulton, Mo

17. (a) Informant Funeral Home

(b) Date thereof July 11 1943

18. (a) Signature of funeral director Eli Bell

(b) Address Fulton, Mo.

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

**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.....

*Eli Bell*

Licensed Embalmer No. *2130*

P. O. Address.....

*Fulton, Md*

**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.**

DEPT. OF HEALTH  
DIVISION OF HEALTH  
STATE OF MARYLAND  
Baltimore, Md.

Registration District No. 47 Primary Registration District No. 2008 Registrar's No. 209

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Sultan  
(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.  
In this community years, months or days

3. (a) PRINT FULL NAME Henrietta Kibby  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex 7  
5. Color or race B  
6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased out (Month) Day (Year)

8. AGE: Years 77 Months 9 Days less than one day min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Date received local registrar July 10 1943 (b) Registrar's signature Joie M. ...

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.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July year 1943 hour minute M.  
21. I hereby certify that I attended the deceased from that I saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death.

Due to  
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 (M. D. or other) Address Date signed

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-24546