

ED SEP 11 1943

Primary Registration District No. 10011000

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

1. PLACE OF DEATH: **BUCHANAN**

(a) County BUCHANAN

(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: MU. MATHU. HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hrs. 40 min (Specify whether years, months or days)

In this community 6 hrs. 40 min

3. (a) PRINT FULLNAME Donald Dean Hughes

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced SD

6. (b) Name of husband or wife No 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 25, 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 6 hr. 40 min.

9. Birthplace St. Joseph, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name Mrs. Margaret Elizabeth Hughes

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

16. (a) Informant Margaret Hughes

(b) Address 2407 F. Evans

17. (a) Burial (b) Date thereof 8/26/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director John E. Rumba

(b) Address 6054 Pryor Ave, St. Joseph, Mo

19. (a) 8/26/43 (b) Rose Neigoy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buch

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

(d) Street No. Mo. Mat (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25th
year 1943 hour 8:00 minute 0 A. M.

21. I hereby certify that I attended the deceased from 1:20 a.m. 8-25-43 to 8:00 a.m. 8-25-43
that I last saw him alive on 8-25-43 and that death occurred on the date and hour stated above.

Immediate cause of death Prenatality

Due to _____

Due to _____

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

Major findings: Of operations 159

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 0

23. Signature P. C. Whallow M.D. (M. D. or other)
Address 620 Francis St. Joseph Date signed 8-25-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 body was not embalmed, Registered Apprentice No. _____
working under my personal supervision.

Signed

John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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.