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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 92

LED DEC 9 1943  
Registration District No. 172

Primary Registration District No. 4328

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

1. PLACE OF DEATH:

(a) County MISSISSIPPI

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

(c) Name of hospital or institution: NONE  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community ALL OF LIFE years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MISSISSIPPI

(c) City or town BERTRAND  
(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 MAYME LEE HIBBS

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

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

4. Sex F

5. Color or race WHITE

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife JOHN WILLIAM HIBBS

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased DEC. 17 1890  
(Month) (Day) (Year)

8. AGE: Years 52 Months 11 Days 5  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation HOUSEWIFE

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

12. Name GEORGE LEFLER

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

14. Maiden name CHARLIE STRICKLAND

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

16. (a) Informant MARGUERITE HAMPTON

(b) Address CHARLESTON, MO

17. (a) BURIAL (Burial, cremation, or removal)

(b) Date thereof 11-24-43  
(Month) (Day) (Year)

(c) Place: burial or cremation ARMER CEMETERY BERTRAND, MO

18. (a) Signature of funeral director [Signature]

(b) Address Charleston, Mo

19. (a) 12/1/43 (Data received local registrar)

(b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 22  
year 1943 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from 11-19-42  
to 11-22 1943  
that I last saw her alive on 11-22 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Hamiplogia

Due to Cerebral Hemorrhages

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

Other conditions Seen  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 50g

Duration 1 day

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 [Signature] (M. D. or other)

Address Charleston, Mo Date signed 11-24-43

RECEIVED

District Health Office No. 2

District File Number 1243-154

Date Filed 12-8-43

Date

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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 John F. Nunnally Jr

Licensed Embalmer No. 3857

P. O. Address Charleston, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. dec  
Registrar's No. 92

Registration District No. 217 Primary Registration District No. 4028

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

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Bethland  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

years, months or days

3. (a) PRINT FULL NAME Mayme Lee Hibbs

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 married

6. (b) Name of husband or wife John Wm. Hibbs 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased dec 17 (Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 1 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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) \_\_\_\_\_ (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) Dec 20 1943 (b) Mrs Lou Ma... (Date received local registrar) (Registrar's signature)

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 Dec 2  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

Duration

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) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

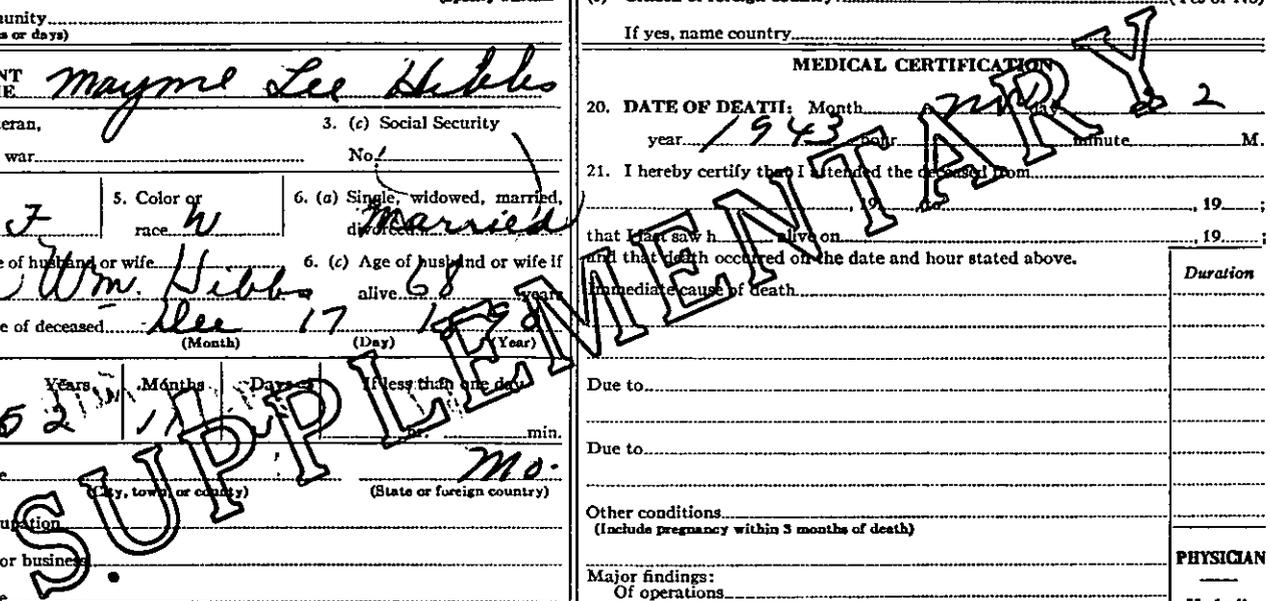
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(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 \_\_\_\_\_



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