

FILED MAY 10 1944 7
Registration District No. _____

Primary Registration District No. 3023

Registrar's No. 80

1. PLACE OF DEATH:

(a) County Henry Clinton
(b) City or town _____
(c) Name of hospital or institution: Rains Nursing Home
(d) Length of stay: In hospital or institution about 11 months
In this community years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stearns
(c) City or town Deepwater
(d) Street No. _____
(e) Citizen of foreign country? _____

3. (a) PRINT FULL NAME Solathiel L. Hubbard

3. (b) If veteran, name war _____ 3. (c) Social Security No. no

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

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

7. Birth date of deceased Dec 11 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant social security

(b) Address Clinton Mo

17. (a) Burial (b) Date thereof April 7 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deepwater cem

18. (a) Signature of funeral director Tom Stuart

(b) Address Deepwater Mo

19. (a) April 26 1944 (b) Georgia Kitchen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 26
year 44 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from 4-6-44
to 4-10-44
that I last saw him alive on 4-10-44
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach
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? _____
(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 R. J. Powell (M.D. or other)
Address Clinton Mo Date signed 4/26/44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number

4-44-621
5-8-44

Date Filed

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.....

James H. Hurd

Licensed Embalmer No.....

2782

P. O. Address.....

Deepwater, 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.