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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED NOV 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34923

State File No. _____

Registration District No. 249

Primary Registration District No. 5846

Registrar's No. _____

1. PLACE OF DEATH *roadway*

(a) County *Lincoln Twp.*

(b) City or town *Near Falsmo Mo.*
(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 _____ (b) County *74*

(c) City or town _____ (If outside city or town limits, write "RURAL") *0*

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____ *0*

3. (a) PRINT FULL NAME *OTTIS B HUMPHREYS*

3. (b) If veteran, name war _____ *✓*

3. (c) Social Security No. _____

4. Sex *0* 5. Color or race *W*

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *Oct 25 1867*
(Month) (Day) (Year)

8. AGE: Years *77* Months *0* Days *5*

If less than one day _____ hr. _____ min.

9. Birthplace *Momath Iowa*
(City, town, or county) (State or foreign country)

10. Usual occupation *Lincoln Twp*

11. Industry or business *Farmis*

12. Name *Thomas Humphrey*

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

14. Maiden name *Martha Hillman*

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof *Nov 1 1944*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *High Prairie*

18. (a) Signature of funeral director *Price & Harn*

(b) Address *Almy mo*

19. (a) *Nov 1 1944* (b) *W W Carpenter*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct* day *30* year *1944* hour *3* minute *20 P.M.*

21. I hereby certify that I attended the deceased from *Oct 21 1944 to Oct 30 1944* that I last saw him alive on *Oct 30 1944* and that death occurred on the date and hour stated above.

Immediate cause of death *Chronic Myocarditis* Duration *10 yrs*

Due to *probable Ruptured aortic aneurysm of ruptured teeth over period of 7 years*

Other conditions *12 1 1*
(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) (e) Means of injury *2*

23. Signature *H. E. Wallace* (M.D. or other) *D.O.*

Address *Burlington Mt. Mo.* Date signed *10-31-44*

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

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

W. L. Gee

Licensed Embalmer No.

2539

P. O. Address

Maryville 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.

Now

State File No. _____

Registration District No. 249

Primary Registration District No. 5846

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Osborne
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(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 Otis B. Humphrey

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

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

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

7. Birth date of deceased Oct 25 1944
(Month) (Day) (Year)

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

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

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Miss M. G. Carpenter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madaway

(c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 30 Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____

that I last saw him/her 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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

34923