

FILED DEC 18 1944

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 301

1. PLACE OF DEATH:

(a) County Adair
(b) City or town PIPKSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Prim-Smith
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 day years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LINN
(c) City or town Bucklin
(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 William Grant Hughes

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife May Hughes 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased mar 23 1876 (Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 20 If less than one day hr. _____ min. _____

9. Birthplace New Cambria, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Druggist

11. Industry or business _____

12. Name Hugh Hughes

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

14. Maiden name Unknown

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

16. (a) Informant May Hughes

(b) Address Bucklin, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Mission Cem. Bucklin

18. (a) Signature of funeral director James Funeral Service

(b) Address Bucklin, Mo.

19. (a) 11-12-44 (Date received local registrar) (b) Mrs. L. Wagoner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13 year 1944 hour 5 minute 15 A.M.

21. I hereby certify that I attended the deceased from 11/12/44, 19____, to 11/13/44, 19____; that I last saw him alive on 11/13/44, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia-massive-croupous-bilateral Duration 36 hrs

Due to exposure 2 da

Due to _____ 108

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

Major findings: XX Of operations _____

Of autopsy not done

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 E. S. Smith (M. D. certifier) Address Barlowville Date signed 11/13/44

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

RECEIVED

District Health Officer No. 10

District File Number 12-44-2064

Date Filed DEC 15 1944

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 CA Larson

Licensed Embalmer No. 4037

P. O. Address Quaklin, 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.