

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7287

FILED MAR 14 1945

Registration District No. 322

Primary Registration District No. 44-72-1-87

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town R.F.D. No. 2, Slater, Mo.  
(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 no  
In this community 30 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline  
(c) City or town R.F.D. No. Slater, Mo.  
(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 Robert Breckenridge Hume

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

4. Sex male (5. Color or race white) 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased November 21 1857  
(Month) (Day) (Year)

8. AGE: Years 87 Months 3 Days 23  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation farmer

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

12. Name Stanton Hume

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

14. Maiden name Virginia Ferguson

15. Birthplace No.  
(City, town, or county) (State or foreign country)

16. (a) Informant Joe H. Hume

(b) Address R.F.D. Slater, Mo.

17. (a) burial (b) Date thereof 2-16-'45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall, Mo.

18. (a) Signature of funeral director Hill Brothers

(b) Address Slater, Mo.

19. (a) Feb 17-45 (b) Mrs. John Giger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14  
year 1945 hour 10 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from 2-11-45 to 2-14-45

that I last saw him alive on 2-11-45 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

Due to arterio sclerosis

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 83a

Of autopsy \_\_\_\_\_

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 0

23. Signature J. Mead (M. D. or other) \_\_\_\_\_

Address Slater, Mo. Date signed 2/14/45

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

700

RECEIVED

Sanitary Health Officer No. 3,

Sanitary File Number

Date Filed

2/13/45

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

Sam M Hill

Licensed Embalmer No.

1292

P. O. Address

Slater 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.