

No. 2  
8-43  
17-39  
X3782

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27217

State File No. \_\_\_\_\_

FILED SEP 4 1945

Registration District No. 95

Primary Registration District No. 5329

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Crawford (rural)  
(b) City or town Cuba Route #1 Mo Oak Hill  
(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 Missouri (b) County Crawford 28  
(c) City or town Cuba Route #1 Mo. (rural) 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Oakhill Twp. 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country Life

3. (a) PRINT FULL NAME ANDREW HASKEN HAMBY

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

4. Sex Male 5. Color or race White 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 December 28th 1855  
(Month) (Day) (Year)

8. AGE: Years 89 Months 7 Days 21 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Jerseyville, Illinois, 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

MOTHER FATHER { 12. Name Isaac Hamby  
13. Birthplace Gasconade Co., Mo. 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Eveline  
15. Birthplace Jeneyville Ill. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maude Stubblefield

(b) Address Cuba, Rt. #1, Mo.

17. (a) Burial (b) Date thereof Aug. 21st 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gibson Cemetery

18. (a) Signature of funeral director Jas. H. Hollow

(b) Address Cuba, Mo.

19. (a) Aug 24, 1945 (b) Mrs. R. D. Russell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19th  
year 1945 hour 12 Noon minute \_\_\_\_\_ p. M.

21. I hereby certify that I attended the deceased from 5-10 #3 to 8-7 1945  
that I last saw him alive on 8-7 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
myocarditis  
Due to Endocarditis  
Due to Infection

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

Major findings: Of operations \_\_\_\_\_ ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Of autopsy \_\_\_\_\_ 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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ While at work \_\_\_\_\_ Means of injury 2  
23. Signature R. G. Neuman D.O.  
Address Cuba, Mo. Date signed 8-26-45

1308

(Licensed Embalmer's Statement on Reverse Side)

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

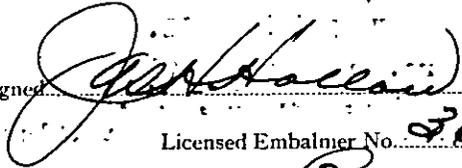
**STATEMENT BY LICENSED EMBALMER**

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.....



Licensed Embalmer No.....

2643

P. O. Address.....

Rossmore, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Sept

State File No. \_\_\_\_\_

Registration District No. 90Primary Registration District No. 5329

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Crawford  
 (b) City or town Rural  
 (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)3. (a) PRINT FULL NAME Andrew H Hamby3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex M 5. Color or race W6. (a) Single, widowed, married,  
divorced md6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased Dec 28 - 1905  
(Month) (Day) (Year)8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
\_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Illinois  
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

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) Sept 6 - 1945 (b) Mrs. S. D. Powell  
(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 Aug Day 19 Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.  
Immediate cause of death myocarditis

Duration

Endocarditis

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

Due to (obstruction frominfection of feet)  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_Of autopsy \_\_\_\_\_ 928

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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

S-27217