

S. No. 2
M-8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27230

State File No. _____

FILED 96
REGISTRATION DISTRICT No. 5-3-82
SEPT 11 1945

Primary Registration District No. 5-3-82

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Texas Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sherman Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Texas Rural
(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 _____

3. (a) PRINT FULL NAME MARTHA MAHALEY HURST

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Otis 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Oct 17 1891
(Month) (Day) (Year)

8. AGE: Years 53 Months 10 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name G. M. Attebery

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

14. Maiden name Elizabeth Williams

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

16. (a) Informant Otis Hurst

(b) Address Texas Mo

17. (a) Burial (b) Date thereof 8-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hopewell

18. (a) Signature of funeral director R B Jones

(b) Address 3 Higgins Mo

19. (a) 9-4-45 (b) R B Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29
year 1945 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from Aug 5 1945 to Aug 7 1945
that I last saw her alive on Aug 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations None
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)
(e) Means of injury _____
23. Signature La Flores (M.D. or other) MP
Address Libana Mo Date signed Aug 29/45

Duration 4 days
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

13711

RECEIVED

Health Officer No. 71

District file number 8-45-921

Date Filed 9-10-45

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 Morris B. Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, 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.