

No. 9-4-41
-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

34114

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 4278

Primary Registration District No. 4278

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Miller
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Residence 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Native years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Miller
(If outside city or town limits, write "RURAL")
(d) Street No. 1114 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Murty Mae Hudspeth

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 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 _____ years

7. Birth date of deceased 10 - 1 - 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Dade Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name James B. Hixon

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

14. Maiden name Porter

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

16. (a) Informant Truman Hudspeth

(b) Address Miller Mo.

17. (a) Burial (b) Date thereof 10-10-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pennsboro

18. (a) Signature of funeral director Maxwell Lemian

(b) Address Miller Mo.

19. (a) 10-9-45 (b) W. S. Burmy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 6
year 1945 hour 7 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan 1 1945 to Oct 10 1945
that I last saw h. E alive on 10-10-45
and that death occurred on the date and hour stated above.

Immediate cause of death Mae hypertension

Due to Refused food for 2 weeks

Due to insanity

Other conditions. (Include pregnancy within 3 months of death) 2000

Major findings: Of operations _____
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 W. S. Burmy (M. D. or other) 45
Address _____ Date signed 10-7-45

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

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

MOTHER FATHER

1534

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 2,

District File No. 1145-7075-

Date Filed **NOV 7 1945**

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 *J. R. Seiman*
Licensed Embalmer No. 3297
P.O. Address Miller 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.

Registration District No. 176

Primary Registration District No. 4278

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

1. PLACE OF DEATH: Lawrence
 (a) County Lawrence
 (b) City or town Mellor
 (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 _____
 (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 _____

3. (a) PRINT FULL NAME Mrs. M. Hudspeeth
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct Day 1 Year 1945 Hour _____ Minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____
 that I have seen him/her live on _____ 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Oct 1 (Month) (Day) (Year)
 8. AGE: Years 72 Months 0 Days _____ (less than one day) min.

Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

12. Name Unknown

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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal) (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) (W. S. Burns)
 (Date received local registrar) (Registrar's signature)

Duration _____
 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?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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