

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF PUBLIC HEALTH  
**FILED** MAY 9 1946 **STANDARD CERTIFICATE OF DEATH**

14241

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

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 139

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Esther  
(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 St. Francois  
(c) City or town Esther  
(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 Ada C. Hibbitts

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 William Lee 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased February 9, 1879  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>2</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace St. Francois County  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name David Burch  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Bartley  
15. Birthplace St. Francois County, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant William L. Hibbitts

(b) Address Esther, Missouri

17. (a) Burial (b) Date thereof April-17-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director Sparks Funeral Home

(b) Address 300 Taylor Ave, Flat River, Mo

19. (a) 4-19-46 (b) Esther Rudloff  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14  
year 1946 hour 7:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Nov 13  
1945 to April 14 1946  
that I last saw her alive on April 14 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of P. P. ovary and adjoining tubes  
Due to \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 490  
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?

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_

23. Signature W. W. Zuppan (M. D. or other) DO  
Address Flat River, Mo Date signed 4/17/46

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

RECEIVED

District Health Officer No. 4

District File Number 546-2116

Date Filed 5-8-46

---

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 Murphy Sparks  
Licensed Embalmer No. 4236  
P. O. Address Flat River 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.