

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14653**

FILED APR 29 1947 **390**

Registration District No. _____

Primary Registration District No. **4442**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Randolph**

(b) City or town **Highes**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **at home**
(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 time**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Randolph**

(c) City or town **Highes**
(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 **RICHARD FLORENCE HURSHMAN**

(b) If veteran, name war **no**

(c) Social Security No. **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **4** -th year **1947** hour **15** till **12** minute **noon** M.

21. I hereby certify that I attended the deceased from **October 15**, 1944, to **February**, 1947; that I last saw him alive on **Feb 3**, 1947 and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Wife Fannie Hurshman**

6. (c) Age of husband or wife if alive **84** years

7. Birth date of deceased **Nov 16 1876**
(Month) (Day) (Year)

Immediate cause of death **myocardial insufficiency** Duration **8 mo**

Due to **myocardial infarction**

Due to **coronary occlusion**

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **70** Months **2** Days **19** If less than one day hr. _____ min. _____

9. Birthplace **Country Missouri**
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

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

10. Usual occupation **Coal mining**

11. Industry or business **Coal miner**

12. Name **ELI HURSHMAN**

13. Birthplace **Country Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **SARAH ANN ROBB**

15. Birthplace **Country Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Ann Kirby**

(b) Address **Highes**

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? _____

17. (a) **Burial** (b) Date thereof **27 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **J. S. Roberson**

(b) Address **Highes Mo**

19. (a) _____ (b) **J. W. Wynn**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury **2**

23. Signature **J. Robinson** (M.D. or other) **D.O.**

Address **Highes, Mo** Date signed **2-6-47**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

X

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 H S Robinson

Licensed Embalmer No. 3001

P. O. Address Higbee

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. J

Registration District No. 390

Primary Registration District No. 4442

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

1. PLACE OF DEATH:
 (a) County Randolph
 (b) City or town Hughes
(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 years, months or days)

3. (a) PRINT FULL NAME Richard E. Hurshma
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased jun 16 1926
(Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days _____
(Unless than one day hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (b) J. H. Hurshma
(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 July Year 1972 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, 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 _____

Duration

Due to _____

Due to _____

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?

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed 6/12-47

14053