

No. 2
5-43
17-39
X36671

FILED JUL 14 1947
Registration District No. **1947**

Primary Registration District No. **5357**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Davies**

(b) City or town **Rural Benton Twp**
(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 **81 years** (years, months or days)

3. (a) PRINT FULL NAME **Nancy M Hibbs**

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 **Widowed**

6. (b) Name of husband or wife **James A Hibbs Decd.** 6. (c) Age of husband or wife if alive **81** years

7. Birth date of deceased **Dec 20 1857**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	89	5	10	hr. min.

9. Birthplace **Near Waterloo Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business **Housewife**

12. Name **Henry Meyer**

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

14. Maiden name **Sarah Linder**

15. Birthplace **not known** (City, town, or county) (State or foreign country)

16. (a) Informant **elo Hibbs**

(b) Address **Mc Fall MO**

17. (a) **Burial** (b) Date thereof **June 1-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mc Fall MO**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Pattonsburg mo**

19. (a) **6-4-47** (b) **Virginia M Englebert**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Davies 31**

(c) City or town **Pattonsburg Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) **Benton Twp**

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **30**
year **1947** hour **4:15** minute **P.** M.

21. I hereby certify that I attended the deceased from **April 16** 1947, to **May 30** 1947;
that I last saw her alive on **May 30** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **cancer of the breast and hip fracture** Duration _____

Due to _____

Due to _____

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

Major findings: **50**
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 **[Signature]** (M. D. or other) _____

Address **Pattonsburg mo** Date signed **5/27/47**

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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. 2887

P. O. Address. Pattersonburg 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.

July

Registration District No. 99

Primary Registration District No. 5357

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Davies
(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 Nancy M. Hibbs
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 _____
7. Birth date of deceased Dec 20
(Month) (Day) (Year)

8. AGE: Years 89 Months _____ Days _____ If less than one day
hr. _____ min. _____

9. Birthplace Java
(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) _____
(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 _____ Year 1947 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above. Duration
Immediate cause of death _____

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) Accidentally fell in the home.

(b) Date of occurrence Jan 28-1947

(c) Where did injury occur? in home Davies Co mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at her home

(Specify type of place) (e) Means of injury _____

23. Signature John F. Porter (M. D. or other) _____

Address Portland mo. Date signed July 16/47

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

SUPPLEMENTARY

S-20455