

FILED DEC 3 1947

Registration District No. **241**

Primary Registration District No. **4360**

Registrar's No. **42**

1. PLACE OF DEATH:
 (a) County **New Madrid**
 (b) City or town **Portageville**
 (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 **12 years**
 In this community **12 years**
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Will Hughes**
 3. (b) If veteran, name war: No.
 3. (c) Social Security No.

4. Sex **MALE** 2
 5. Color or race **BLACK**
 6. (a) Single, widowed, married, divorced **9**
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive **9** years
 7. Birth date of deceased **JAN 30 1880**
 (Month) (Day) (Year)

8. AGE: Years **67** Months **9** Days **12**
 If less than one day hr. min.

9. Birthplace **don't know** 9
 (City, town, or county) (State or foreign country)

10. Usual occupation **Porter**

11. Industry or business

MOTHER FATHER
 12. Name **Unknown** 9
 13. Birthplace (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown** 9
 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant **Bob Young, Jr.**
 (b) Address **Portageville, Mo.**

17. (a) **Burial** (b) Date thereof **11-14-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Portageville Cemetery**

18. (a) Signature of funeral director **DeLisle FUNERAL PARLOR**
 (b) Address **Portageville, Missouri**

19. (a) **11-14-47** (b) **Ellen DeLisle**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **New Madrid** 72
 (c) City or town **Portageville, MO** 6
 (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 **NOV** day **10**
 year **1947** hour **10** minute **0** M.

21. I hereby certify that I attended the deceased from **Nov 7**
1947, 19 to **Nov 12**, 19 **47**
 that I last saw **last** alive on **Nov 9**, 19 **47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **fractured skull** Duration **1**

Due to
 Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
 Of autopsy
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 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 **H. T. [illegible]** (M. D. or other)
 Address **Portageville, Mo.** Date signed **11/11/47**

RECEIVED
District Health Office No. 2
District File Number 1247-12-7
Date Filed 12-1-47

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 *Not Embalmed*
.....
..... Licensed Embalmer No.....
..... P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. Dec

Registration District No. 24

Primary Registration District No. 4060

Registrar's No. 42

1. PLACE OF DEATH:
(a) County new Madrid
(b) City or town Portageville
(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 Will Hughes
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Jan 30 1870
(Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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 _____ Day _____ Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 Colon. Perforation

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 H. V. Kelly (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

39020

Handwritten notes, possibly including "P. V. J." and other illegible characters.