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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 5 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44716

Registration District No. 255 Primary Registration District No. 5875 Registrar's No.

1. PLACE OF DEATH:
(a) County Oregon
(b) City or town Thomasville Mo.
(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 84 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Oregon 75
(c) City or town Thomasville Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Missouri Ann Hull
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 W 2
6. (b) Name of husband or wife Ira Hull
6. (c) Age of husband or wife if alive Dec years
7. Birth date of deceased Sept. (Month) 14 (Day) 1863 (Year)

8. AGE: Years	Months	Days	If less than one day
84	2	24	✓ hr. ✓ min.

9. Birthplace Thomasville Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name John George Huddleston
13. Birthplace Oregon County Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Sutton
15. Birthplace Kentucky (City, town, or county) (State or foreign country)
16. (a) Informant Bertha Hull
(b) Address Thomasville Mo.
17. (a) B. (Burial, cremation, or removal) (b) Date thereof 12-10-47 (Month) (Day) (Year)
(c) Place: burial or cremation Union Hill
18. (a) Signature of funeral director Robertson
(b) Address West Plains Mo.
19. (a) 3-11-48 (Date received local registrar) (b) Mrs W. C. Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8
year 1947 hour 1 minute 15 P. M.
21. I hereby certify that I attended the deceased from 1/31, 1947, to 12/8, 1947;
that I last saw her alive on 12/5, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to Diabetes Mellitus	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Col
Of autopsy

PHYSICIAN
Underline the cause of 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 R. E. Hogan (M. D. Author)
Address West Plains, Missouri Date signed

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District [illegible] No. 5
District File No. 348155
Date Filed 3-4-48

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 Troy R. Troyo, Registered Apprentice No. 431, working under my personal supervision.

Signed Donald D Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains 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.

No. 2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 44716 March

Registration District No. 855 Primary Registration District No. 5875 Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Thomasville
(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)

In this community

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 Missouri A. Hull

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~~ Ira Hull

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

7. Birth date of deceased Sept 14 (Month) (Day) 1864 (Year)

8. AGE: Years 84 Months 2 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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)

MOTHER

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation Burial Thomasville

18. (a) Signature of funeral director

(b) Address

19. (a) 3-11-48 (Date received local registrar) (b) Miss W Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 8 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

5-44716