

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FILED JAN 17 1948

Registration District No. 7

Primary Registration District No. 3008

Registrar's No. 1

1. PLACE OF DEATH:  
(a) County CALLAWAY  
(b) City or town FULTON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: STATE HOSPITAL No. 12  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 mo 14 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County HOWARD <sup>14</sup>  
(c) City or town NEW FRANKLIN <sup>1</sup>  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2  
(If rural, give location) <sup>0</sup>  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME NANNIE HUGHES  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JANUARY day 4  
year 1948 hour 9:15 PM minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from MAY 21, 1947  
to JANUARY 4, 1948  
that I last saw her alive on JANUARY 4, 1948  
and that death occurred on the date and hour stated above.

4. Sex FEMALE <sup>8</sup> Color or race NEGRO  
6. (a) Single, widowed, married, divorced UNKNOWN  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death CARONIC MYOCARDITIS and MYOCARDIAL DEGENERATION  
Due to RHEUMATISM  
Other conditions SIMPLE SENILE DETERIORATION  
(Include pregnancy within 3 months of death)

7. Birth date of deceased UNKNOWN  
(Month) (Day) (Year)  
8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Duration + 7 mo  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace HOWARD Co Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation MIDWIFE

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 EFFIE TUCKER  
(b) Address NEW FRANKLIN, Mo  
17. (a) Removal (b) Date thereof Jan 5-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation New Franklin Mo  
18. (a) Signature of funeral director P. S. Duncan  
(b) Address New Franklin Mo  
19. (a) Jan 5 48 (b) Joyce M. ...  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature Joyce M. ... (M. D. or other) M.D.  
Address STATE HOSPITAL No. 12 Date signed 1-1-48

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

14  
1  
2

MOTHER FATHER

Date filed 11/5/48  
Number 115/48

RECEIVED  
District Health Officer No. 5

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. L. Rice.....

Licensed Embalmer No. 3515

P. O. Address New Franklin, 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.