

No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUL 30 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22029

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 197

1. PLACE OF DEATH:  
(a) County ADAIR  
(b) City or town KIRKSVILLE  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution COMMUNITY NURSING HOME #4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 3 MONTHS years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County SCOTLAND  
(c) City or town GORIN (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 RACHEL A HIBBS  
(b) If veteran, name war L  
(c) Social Security No. L

MEDICAL CERTIFICATION  
20. DATE OF DEATH, Month JULY day 16<sup>th</sup>  
year 1948 hour 12 minute 25A M.  
21. I hereby certify that I attended the deceased from April 1948, to July 16, 1948;  
that I last saw him alive on July 16, 1948  
and that death occurred on the date and hour stated above.  
Immediate cause of death Circ Failure

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced W L  
6. (b) Name of husband or wife ALBERT HIBBS  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: MARCH 6 1860  
(Month) (Day) (Year)

Due to Bere Hemmerage Days  
Due to Arp Hyp years  
Other conditions Cancer of Breast (L) years  
(Include pregnancy within 3 months of death)

8. AGE: Years 88 Months 4 Days 11  
If less than one day hr \_\_\_\_\_ min \_\_\_\_\_  
9. Birthplace SCOTLAND Co. Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation HOUSE WIFE

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 50  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name WARDEN HAYDEN I  
13. Birthplace KY  
14. Maiden name REBECCA ENGLISH  
15. Birthplace KY  
(City, town, or county) (State or foreign country)  
16. (a) Informant R A Hibbs  
(b) Address GORIN Mo  
17. (a) BURIAL (b) Date thereof 7-18-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation GORIA CEMETERY  
18. (a) Signature of funeral director A. W. Reynolds  
(b) Address MEMPHIS Mo  
19. (a) 7-22-48 (b) Kate Lambert  
(Date received local registrar) (Registrar's signature)

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? L  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature R. Jones (M. D. or other) \_\_\_\_\_  
Address 107 1/2 W Washington Date signed 7-25-48  
City Turnersville Mo

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

RECEIVED

District Health Officer No. 70

District File Number 7-48-1357

Date Filed JUL 28 1948

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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 Neal Payne

Licensed Embalmer No. 2550

P. O. Address Memphis, Tenn.

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.