

FILED AUG 18 1948

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 232

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. 1
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 10 14
 In this community 10 14 days (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway 14
 (c) City or town Fulton 1
 (If outside city or town limits, write "RURAL") 2
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MATTIE IRVINE

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 WIDOW
 6. (b) Name of husband or wife PK 6. (c) Age of husband or wife if alive DK years
 7. Birth date of deceased: Oct 4 1874
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 8 3 hr. min.

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

10. Usual occupation Hospital attendant

11. Industry or business _____

12. Name Lafayette Hubbs
 13. Birthplace Ohio Canada
 (City, town, or county) (State or foreign country)
 14. Maiden name Martha Hubbs
 15. Birthplace France
 (City, town, or county) (State or foreign country)

16. (a) Informant State Hospital, Fulton, Mo.

(b) Address Fulton, Mo.

17. (a) Burial (b) Date thereof 8-9-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Mo.

18. (a) Signature of funeral director Halley General Non

(b) Address 746 1/2 E. Fulton, Missouri

19. (a) 8-9-1948 (b) Joie M. Schreff
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th
 year 1948 hour 5:35 minute P M.

21. I hereby certify that I attended the deceased from 1 June
 1948, to August 7, 1948;
 that I last saw her alive on August 7, 1948;
 and that death occurred on the date and hour stated above.

Immediate cause of death Right
Lobar pneumonia

Duration

Due to _____

Due to _____

Other conditions Senile and fracture
 (Include pregnancy within 3 months of death)

Major findings: Right hip by falling
 Of operations on the wound

Of autopsy 1866

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16
11

(a) Accident, suicide, or homicide (specify) 16

(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)
Food store

23. Signature Wm. H. Hefley (M. D. or other)

Address State Hospital No. 1 Date signed 7 Aug 48

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

RECEIVED
District Health Officer No. 9,
District File Number AUG 16 1948
Date Filed

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 *Denzil C. Browning*

Licensed Embalmer No. *2724*

P. O. Address: *Gulton 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.

Registration District No. 47 Primary Registration District No. 2008

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Mathie Ironic
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color of 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 _____ years

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

8. AGE: Years 72 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 _____

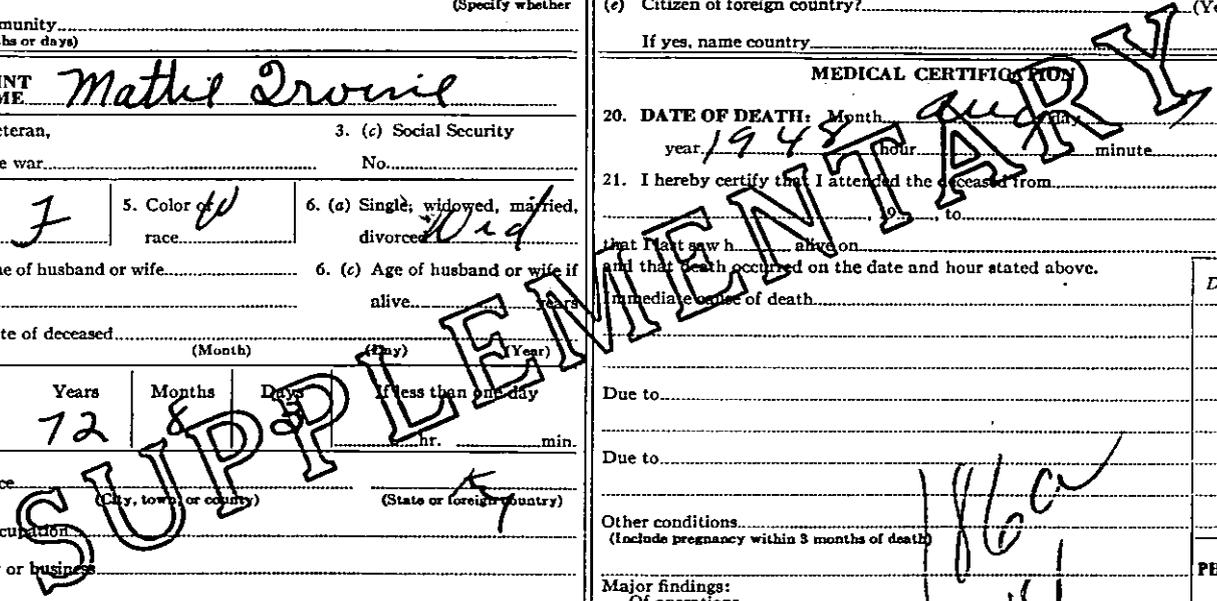
MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1948 (hour) _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Duration _____
Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ACCIDENT
(b) Date of occurrence 2/26/48
(c) Where did injury occur? FULTON, CALLAWAY, MISSOURI
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
PT FELL ON THE WARD IN HOSPITAL
While at work? NO PT WAS VERY FRIBLE
(Specify type of place) (c) Means of injury
HAND WEAK.
23. Signature Wayne H. [Signature] (M. D. or other) _____
Address 520 N. [Address] Date signed 3/2/48
Fulton, Mo.



MOTHER FATHER

