

No. 2  
17-39  
229484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33336**

FILED OCT 29 1948

Registration District No. **129**

Primary Registration District No. **4249**

Registrar's No. **45**

1. PLACE OF DEATH:

(a) County **JEFFERSON**  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**HILLSBORD CONVALESCENT HOME 4**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 MONTHS**  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **JEFFERSON**  
(c) City or town **CRYSTAL CITY Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **303 1/2 7TH ST.**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **NELLIE N. AUBUCHON**

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 **WIDOWED**

6. (b) Name of husband or wife **DECEASED** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **DEC 22, 1879**  
(Month) (Day) (Year)

8. AGE: Years **68** Months **9** Days **27** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **? ILLINOIS**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **JOHN NOKES**  
13. Birthplace **UNKNOWN**  
(City, town, or county) (State or foreign country)  
14. Maiden name **ELIZABETH RUSH**  
15. Birthplace **? ARKANSAS**  
(City, town, or county) (State or foreign country)

16. (a) Informant **C. L. AUBUCHON**  
(b) Address **303 1/2 ST. CRYSTAL CITY Mo**

17. (a) **BURIAL** (b) Date thereof **OCT 21, 1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BURGESS Cem. Hannibal Mo**

18. (a) Signature of funeral director **HEILIGTRAG FW HOME**

(b) Address **KIMMSWICK Mo**

19. (a) **10-23-48** (b) **Spilhaus**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **19**  
year **1948** hour **5** minute **55 A.** M.

21. I hereby certify that I attended the deceased from **Sept** 19 **Oct** 19 **1948**  
that I last saw her alive on **Oct 19** 19 **48**  
and that death occurred on the date and hour stated above.

Immediate cause of death **chronic pneumonia**  
**Chronic bronchitis**  
**Myocardial infarction**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions **Essen int hyper**  
(Include pregnancy within 3 months of death)  
**flexion - menstrual**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy **H&P**

Duration

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 **D. B. Twenty** (M. D. or other) **D.A.**  
Address **Hannibal Mo** Date signed **10-23-48**

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

OCT 27 1948

NOV 9 1948

**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, ~~and~~ by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Elmer A. A. Lighty*

Licensed Embalmer No. \_\_\_\_\_

*357*

P. O. Address \_\_\_\_\_

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. nor  
Registrar's No. 4J-

Registration District No. 159

Primary Registration District No. 4249

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

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Hillsdale 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 \_\_\_\_\_  
years, months or days

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 Nellie N. Dubucha

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 \_\_\_\_\_

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

7. Birth date of deceased Feb 22 1900  
(Month) (Day) (Year)

8. AGE: 68 Years 9 Months 20 Days (Unless than one day)  
hr. \_\_\_\_\_ min.

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

10. Usual occupation sewwife

11. Industry or business home

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year \_\_\_\_\_ 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. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

S-33336

R.P.