No. 2
8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 6 1949

Registration District No. 70

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39622

Primary Registration District No. 5282

Registrar's No. 66

1. PLACE OF DEATH:

(a) County Clark

(b) City or town Rural Sweet Home Twp (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 Missouri (b) County Clark 23

(c) City or town Revere (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 Robert B. McHugh

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mystle A. Farhner

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

7. Birth date of deceased May (Month) 18 (Day) 1870 (Year)

8. AGE: Years 78 Months 7 Days 8 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business ✓ ✓

FATHER
12. Name Aquilla McHugh
13. Birthplace (City, town, or county) Pennsylvania (State or foreign country)

MOTHER
14. Maiden name Ladoski Bruner
15. Birthplace Warren Co. (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Mrs Wayne Halferty

(b) Address Revere Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-48 (Month) (Day) (Year)

(c) Place: burial or cremation Revere Mo. Cemetery

18. (a) Signature of funeral director Fred J Karle

(b) Address Kahoka Mo.

19. (a) 12/31-48 (Date received local registrar) (b) J R Bridges (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26th year 1948 hour 9 minute 30 P M.

21. I hereby certify that I attended the deceased from Dec 24, 1948 to Dec 26, 1948 that I last saw him alive on Dec 26, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia ✓	
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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 J L McConnell (M. D. or other)

Address Revere Mo Date signed 12/26/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 1-49-2
Date Filed JAN 4 - 1949

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 Fred J Karle

Licensed Embalmer No. 1023

P. O. Address Kahoka, 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.

S. No. 2B
1-3-45
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. Jon

Registration District No. 70 Primary Registration District No. 5282 Registrar's No. 66

1. PLACE OF DEATH:

(a) County Clark

(b) City or town Sweet Home Rural (If outside city or town limits, write "RURAL" or 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 Robert B. McHugh

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W/C

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 18 (Day) 18 (Year)

8. AGE: Years 78 Months 7 Days 8 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec day 26 year 1948 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 Bronchial Pneumonia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

107

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J R Bridges (M. D. or other)

Address Kahoka Mo Date signed

SUPPLEMENTARY

5-39622