S. No. 300
v. 10-48

FILED MAR 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7882

BIRTH NO. _____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 4158 Registrar's No. 19

30

1. PLACE OF DEATH
a. COUNTY: Dallas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buffalo
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Buffalo Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE
b. COUNTY: 20
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sylvester
b. (Middle): M.
c. (Last): Hughes

4. DATE OF DEATH (Month) (Day) (Year): 3-2-49

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 2-2-1867
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months 4 Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Old age Pensior
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: John W. Hughes
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Alice Hughes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Alice Hughes — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of rt. antrum — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ?
DUE TO (c) ? 196X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NO
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): NO m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 1948, *to* Feb 2, 1949, *that I last saw the deceased alive on* Feb 2, 1949 *and that death occurred at* 2:15 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. C. Plummer MDU
23b. ADDRESS: Buffalo Mo
23c. DATE SIGNED: 3-3-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-4-49
24c. NAME OF CEMETERY OR CREMATORY: Mission Ridge
24d. LOCATION (City, town, or county) (State): Dallas Co. Mo.

DATE REC'D BY LOCAL REG.: 3-19-49
REGISTRAR'S SIGNATURE: Mrs J. B. Jones 80
25. FUNERAL DIRECTOR'S SIGNATURE: Montgomery-Vaughan — ADDRESS: Buffalo Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 7
District File Number 2-4-9-26
Date Filed 3-21-49

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 ..... Student Embalmer No. ....., working under my personal supervision.

Signed Clyde Montgomery

Signed ..... Student Embalmer

Licensed Embalmer No. 3592

P. O. Address Buffalo, 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.