

FILED AUG 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23045**

BIRTH NO. _____ REG. DIST. NO. 120 PRIMARY REG. DIST. NO. 4194 Registrar's No. 27

38
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1. PLACE OF DEATH a. COUNTY Gentry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Gentry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Albany		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Albany	
c. LENGTH OF STAY (in this place) 6 Mrs.		d. STREET ADDRESS (If rural, give location) 10	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1			

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) Angeline	c. (Last) Hurst	4. DATE OF DEATH (Month) (Day) (Year) 7-23-49
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 28 1871	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 11 Days 25	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Gentry Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Phillip Lane	13b. MOTHER'S MAIDEN NAME Anna B. Cofer	14. NAME OF HUSBAND OR WIFE Archibald Hurst
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elmer Lane Albany, Mo. R.F.D.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute Cerebral Hemorrhage		Short
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Intestinal Obstruction DUE TO (c)		1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		599 X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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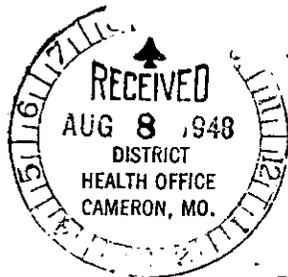
22. I hereby certify that I attended the deceased from July 5th 1949, to July 23rd 1949, that I last saw the deceased alive on July 23rd 1949, and that death occurred at 10 A. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. S. Campbell M.D.	23b. ADDRESS Albany Mo.	23c. DATE SIGNED July 26th
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 25-49	24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery	24d. LOCATION (City, town, or county) (State) Albany, Mo.
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DATE REC'D BY LOCAL REG. Aug. 5-49	REGISTRAR'S SIGNATURE Mrs. Edith Behlender	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albany Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



SEP 23 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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Clifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany 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.