

FILED DEC 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41690**

BIRTH NO. _____ REG. DIST. NO. **267** PRIMARY REG. DIST. NO. **590A** Registrar's No. **133**

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

1. PLACE OF DEATH a. COUNTY Remiscot		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY Remiscot	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HAYTI RURAL		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HAYTI	
c. LENGTH OF STAY (In this place) 6 mos		d. STREET ADDRESS (If rural, give location) COUNTY HOME	
d. FULL NAME OF HOSPITAL OR INSTITUTION COUNTY HOME			

3. NAME OF DECEASED a. (First) John b. (Middle) Hubbard c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) 11 25 1950		
5. SEX M		6. COLOR OR RACE 2 Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	
8. DATE OF BIRTH UNKNOWN		9. AGE (In years last birthday) 70		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) UNKNOWN 9	

13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE UNKNOWN	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Insurance record ADDRESS _____	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Central Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
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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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **May 1**, 1950, to **Nov. 24**, 1950, that I last saw the deceased alive on **Nov. 24**, 1950, and that death occurred at **2 A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. B. Beecher M.D.		23b. ADDRESS Cantharville		23c. DATE SIGNED 12-5-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Nov. 27 1950		24c. NAME OF CEMETERY OR CREMATORY MORRIS RIDGE	
24d. LOCATION (City, town, or county) (State) CANTHARVILLE MO.					

DATE REC'D BY LOCAL REG. 12-22-50		REGISTRAR'S SIGNATURE John St. German		25. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Cantharville ADDRESS _____	
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12-50-319

REC'D
NOV 23 1941

S. B. Beecher, M. D.,
Pemiscot County Health Department,
Caruthersville, Missouri

DEC 23 1941

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.

Student
Student Embalmer

Signed *Noel C. Dean*

Licensed Embalmer No. *3941*

P. O. Address *Caruthersville*

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.