

FILED AUG 24 1953

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. 245 PRIMARY REG. DIST. NO. 3047

1. PLACE OF DEATH a. COUNTY NEWTON		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY NEWTON	
b. CITY (If outside corporate limits, write RURAL and give township) RURAL		c. CITY (If outside corporate limits, write RURAL and give township) RURAL	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) NEOSHO R.F.D. #5	
d. FULL NAME OF HOSPITAL OR INSTITUTION NEOSHO TWP.			

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) R. c. (Last) HUBBS			4. DATE OF DEATH (Month) (Day) (Year) AUG. 10. 1953	
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 10. 1873	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days	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) MAINTNANCE	10b. KIND OF BUSINESS OR INDUSTRY Highway (STATE)	11. BIRTHPLACE (City and State or Foreign Country) LUTTRELL TENN	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME WILLIAM HUBBS	13b. MOTHER'S MAIDEN NAME CATHARINE HICKLE	14. NAME OF HUSBAND OR WIFE ANNA HUBBS.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ANNA HUBBS	ADDRESS NEOSHO MO. R#5
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis of years duration DUE TO (c) Congestive heart failure		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION: 4341	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) m.	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 27, 1953**, to **Aug 10, 1953** that I last saw the deceased alive on _____, 19____, and that death occurred at **2:10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Al Lanson (Degree or title)	23b. ADDRESS Neosho Mo	23c. DATE SIGNED 8/15/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8-12-53	24c. NAME OF CEMETERY OR CREMATORY I. O. O. F.	24d. LOCATION (City, town, or county) (State) NEOSHO MISSOURI
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DATE REC'D BY LOCAL REG. 8-15-53	REGISTRAR'S SIGNATURE Melvin C. Bowman	25. FUNERAL DIRECTOR'S SIGNATURE Orley Thompson Jr.	ADDRESS Neosho Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer ~~No. _____~~

NEWTON COUNTY HEALTH UNIT

District File Number 853-161

Date Filed AUG 20 1953

NEOSHO, MISSOURI

MAR 31 1954

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 Ray L. Adams

Licensed Embalmer No. 4928

P. O. Address Neosho, 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.