MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-037805

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1090

FILED NOV 5 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1 01.28
2 01.30
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4 0
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8 2
9 773.0
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12 4-0
13 1-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY Butler
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff — Length of stay in 1b 24 hrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Poplar Bluff Hosp — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Butler
c. CITY OR TOWN Poplar Bluff, Mo. — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) R# 3 — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Ricky Middle Dale Last Hubbard

4. DATE OF DEATH Month 10 Day 30 Year 62

5. SEX Male

6. COLOR OR RACE White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 10-29-62

9. AGE (last birthday) 14 hrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours 14 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME UNKNOWN

13b. MOTHER'S MAIDEN NAME Dorothy Hubbard

14. NAME OF HUSBAND OR WIFE

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. None

17. INFORMANT Address Dorothy Hubbard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Placenta Insufficiency
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 14 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 10-29-62 to 10-30-62 and last saw ~~her~~ him alive on 10-30-62
Death occurred at 12:15 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William F Turnbull

22b. ADDRESS Poplar Bluff, Mo.

22c. DATE SIGNED 10-30-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE 10-30

23c. NAME OF CEMETERY OR CREMATORY Vale Cemetery

23d. LOCATION (City, town, or county) (State) Butler Co. Mo.

24. FUNERAL DIRECTOR None — ADDRESS Grandfather Mr. Hubbard

25. DATE RECD. BY LOCAL REG. 10/30/62

26. REGISTRAR'S SIGNATURE Thelma Graham

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. Not Embalmed

P. O. Address_____

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.