FILED JAN 16 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42635

Registration District No. 347 Primary Registration District No. 3018 Registrar's No. 61

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

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 509 W Gravel St (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 80 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry
(c) City or town Clinton (If outside city or town limits, write "RURAL")
(d) Street No. 509 W Gravel (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME John F Hughes
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Hughes 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Feb (Month) 19 (Day) 1858 (Year)

8. AGE: Years	Months	Days	If less than one day
82	10	3	____ hr. ____ min.

9. Birthplace Austin (City, town, or county) Texas (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business ____
FATHER 12. Name Robert Hughes
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Sarah J McNew
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Mary Hughes
(b) Address Clinton Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 23 40 (Month) (Day) (Year)
(c) Place: burial or cremation Englewood Cem
18. (a) Signature of funeral director Fred Wilkinson
(b) Address Clinton Mo
19. (a) Dec 27 1940 (Date received local registrar) (b) Dr. J. R. Hampton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1940 hour 4 minute 45 A.M.
21. I hereby certify that I attended the deceased from Nov 15, 1940, to Dec 22, 1940, that I last saw him alive on Dec 21, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death [illegible]	6 da
Due to chronic nephritis & cystitis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature G. Lueker (M. D. or other) M.D.
Address Clinton Mo Date signed 12-23-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 1-41-24
Date Filed 1-3-41

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 ....

........................, Registered Apprentice No. ....

working under my personal supervision.

Signed Fred Wilkinson [handwritten signature, partially cut off]

Licensed Embalmer No. 247

P. O. Address Clinton [handwritten, partially cut off]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

No. 2B
-21-40
X22059

MOORE

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1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ...... (Specify whether
In this community ...... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ...... (b) County ......
(c) City or town ...... (If outside city or town limits write "RURAL")
(d) Street No. ...... (If rural, give location)
(e) If foreign born, how long in U. S. A.? ...... years.

3. (a) PRINT FULL NAME John F Hughes
3. (b) If veteran, name war ......
3. (c) Social Security No. ......
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife ......
6. (c) Age of husband, or wife, if alive ...... years
7. Birth date of deceased Feb (Month) 19 (Day) 1858 (Year)

8. AGE: Years 82 Months 10 Days 3 If less than one day ...... hr. ...... min.

9. Birthplace ...... (City, town, or county) ...... (State or foreign country)
10. Usual occupation ......
11. Industry or business ......
FATHER 12. Name ......
13. Birthplace ...... (City, town, or county) ...... (State or foreign country)
MOTHER 14. Maiden name ......
15. Birthplace ...... (City, town, or county) ...... (State or foreign country)
16. (a) Informant ......
(b) Address ......
17. (a) ...... (Burial, cremation, or removal) (b) Date thereof ...... (Month) (Day) (Year)
(c) Place: burial or cremation ......
18. (a) Signature of funeral director ......
(b) Address ......
19. (a) ...... (Date received local registrar) (b) W. J. R. Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1940 hour ...... minute ...... M.
21. I hereby certify that I attended the deceased from ......, 19......, to ......, 19......; that I last saw h...... alive on ......, 19......; and that death occurred on the date and hour stated above.

Immediate cause of death ...... Duration
Due to ......
Due to ......
Other conditions ...... (Include pregnancy within 3 months of death)
Major findings:
Of operations ......
Of autopsy ......

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ......
(b) Date of occurrence ......
(c) Where did injury occur? ...... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ...... (Specify type of place)
While at work? ...... (e) Means of injury ......
23. Signature G. S. Walker (M. D. or other)
Address Clinton Mo. Date signed ......

SUPPLEMENTARY