

Registration District No. 122

Primary Registration District No. 5693

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County McDonald

(b) City or town Rural - Gril  
(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 2 yrs  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME IDA. MAY HAMBY 510

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife M. D. Hamby

6. (c) Age of husband or wife 57 years  
alive \_\_\_\_\_

7. Birth date of deceased March 18 1880  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>0</u>	<u>0</u>	hr. _____ min.

9. Birthplace Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Geo park 9

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant M. D. Hamby

(b) Address Goodman Mo

17. (a) Burial (b) Date thereof 3-21-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Goodman Mo

18. (a) Signature of funeral director Charles Williams

(b) Address Goodman Mo

19. (a) 4-10-40 (b) Charles Williams  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County McDonald

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Goodman Mo R.F.D. 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18  
year 1940 hour 0 minute 0 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death was found dead in bed by neighbors, he had some 10 to 15 hours

Due to probably died of heart disease had no doctor

Other conditions None  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: None

Of operation None

Of autopsy None

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?  
1-1

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) 9

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

RECEIVED

District Health Officer No. 6,

District File Number 440-1137

Date Filed APR 1 5 1940

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**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.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.**