

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7074**

MAR 17 1941
Registration District No. **124**

Primary Registration District No. **1209**

Registrar's No. **1**

43
003
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Hickory
 (b) City or town Stark - Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: W
(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

3. (a) PRINT FULL NAME Henry V. Womble
 (b) If veteran, name war _____
 (c) Social Security No. _____

4. Sex m
 5. Color or race wh
 6. (a) Single, widowed, married, divorced married
 (b) Name of husband or wife Flora Womble
 (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Mar 24 1866
(Month) (Day) (Year)

8. AGE:
 Years 74 Months 10 Days 3
 If less than one day _____ hr. _____ min.

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

10. Usual occupation: Farmer

11. Industry or business: _____
MOTHER FATHER
 { **12. Name:** Sampson Womble
 { **13. Birthplace:** Mo
 { (City, town, or county) (State or foreign country)
 { **14. Maiden name:** Ellen Miller
 { **15. Birthplace:** Mo
 { (City, town, or county) (State or foreign country)

16. (a) Informant: Flora Womble
 (b) Address: Preston Mo

17. (a) Burial, cremation, or removal: burial
 (b) Date thereof: 1/29/41
(Month) (Day) (Year)
 (c) Place: burial or cremation: Fisher Cemetery

18. (a) Signature of funeral director: J. L. Luckey
 (b) Address: Wheatland Mo

19. (a) Date received local registrar: _____
 (b) J. M. Robertson
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Hickory
 (c) City or town Stark - Rural
(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.? 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 27 year 1941 hour 7 minute 00 M.

I hereby certify that I attended the deceased from Jan 1, 1941, to Jan 27, 1941; that I last saw him alive on Jan 27, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
 Due to: High Blood Pressure
 Due to: _____

Other conditions: _____
(Include pregnancy within 5 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.
 Duration: 7 hr
1 hr

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? 325
While at work? (Specify type of place) (e) Means of injury.
23. Signature: L. A. Blosser (M. D. or other) DMO
 Address: Urbana Mo Date signed: 2/4/41

RECEIVED

District Health Officer No. 7,

District File Number 3-41-419

Date Filed 3-5-41

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

J. P. Luckey

Licensed Embalmer No. 2982

P. O. Address Wheatland, W. Va.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7074

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 364

Primary Registration District No. 5509

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. Hickory
(b) City or town. Stage T.P.
(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.
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Henry V. Womble

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. (Month) (Day) (Year)

8. AGE:

Years 74
Months 10
Days 3

If less than one day by min.

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

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name.

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

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) May 2 1981 (b) J M Robertson (Date received local registrar) (Registrar's signature)

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.

NEURAL CERTIFICATION

20. DATE OF DEATH. Month. Jan day 27 year 1981 hour minute M.

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

Immediate cause of death.

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations.

Of autopsy

Duration

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?

While at work? (Specify type of place) (e) Means of injury.

23. Signature L. A. Glaseo (M. D. or other) Address W. P. ... Date signed

SUPPLEMENTAL

