

ILLU DEC 17 1943

Registration District No. **18**

Primary Registration District No. **4021**

Registrar's No. **18**

1. PLACE OF DEATH:

(a) County **Audrain**  
(b) City or town **Ladonia, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Home 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **50 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Audrain**  
(c) City or town **Ladonia, Mo.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **JOHN WILLIAM MCCUBBIN**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color, race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Frances E. McCubbin** 6. (c) Age of husband or wife if alive **78** years

7. Birth date of deceased **Sept 30 - 1856**  
(Month) (Day) (Year)

8. AGE: Years **87** Months **1** Days **13** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Retired Druggist**

11. Industry or business **Druggist**

12. Name **Thomas McCubbin**

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

14. Maiden name **Elizabeth Shoemaker**

15. Birthplace **Washington D.C.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs J W McCubbin**

(b) Address **Ladonia, Mo.**

17. (a) **Burial** (b) Date thereof **Nov 3 1943**  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation **Ladonia, Mo.**

18. (a) Signature of funeral director **J. W. Trainger**  
(b) Address **Ladonia, Mo.**

19. (a) **Nov 3 - 43** (b) **JW Watkins**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV** day **2**  
year **1943** hour **5** minute **P** M.

21. I hereby certify that I attended the deceased from **Oct. 27**, 19**43** to **NOV. 2**, 19**43**  
that I last saw him alive on **Nov 1-1943**, 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Hypostatic Pneumonia.** Duration **3-Days**

Due to **Hypertension and Arterio-Sclerosis.** **3-years**

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) **108**

Major findings: Of operations \_\_\_\_\_  
Of autopsy **No.** **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 **0**  
23. Signature **W.K. McCall** (M. D. or other) \_\_\_\_\_  
Address **Ladonia, Mo.** Date signed **11-3-43**

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

4  
0  
0

RECEIVED

District Health Officer No. 10

District File Number 12-43-1986

Date Filed DECT 5 1943

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 H. G. Granger, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed H. G. Granger  
Licensed Embalmer No. 1297  
P. O. Address Ladonia, 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.