

FILED JUN 7 1944

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 808 N 4th 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 25 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME DORA HUGHES

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Lem Hughes 6. (c) Age of husband or wife if alive 21 years (Month) (Day) (Year)
7. Birth date of deceased Dec 21 1889

8. AGE: Years 64 Months 5 Days 7 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Domestic

12. Name John H. Shaw

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

14. Maiden name Lucy Spertman

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

16. (a) Informant Blades West

(b) Address 808 N 4th St.

17. (a) Removal (b) Date thereof 5 28 44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tray, Kans.

18. (a) Signature of funeral director Beatrice Gray

(b) Address 812 Pacific St.

19. (a) 5/29/44 (b) Allen S. Dreble (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(d) Street No. 808 N 4th
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 28 year 1944 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from April 22, 1944 to May 28, 1944 and that I last saw her alive on May 20, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency Duration A few months.

Due to

Due to

Other conditions None (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?

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

23. Signature Allen S. Dreble (M. D. or other) M.D.

Address 109 1/2 West Missouri Ave. Date signed 5-29-44

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

2
33
59
7823

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 John T. Miles

Licensed Embalmer No. 3446

P. O. Address: Atchison, Kans

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.