

JAN 19 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Grundy
Township J
City Spickards Mo. (No.)

Registration District No. 329
Primary Registration District No. 4196

File No. 24121-B
Registered No. 16
St. 1 Ward)

2. FULL NAME Will Hurt

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

2. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 13-1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 11 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Grundy Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Alex Hurt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cooper Co Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Minnie Kirk (Address) Spickards Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Merion Co Mo
(STATE OR COUNTRY)

14. INFORMANT Alex Hurt
(Address) Spickards Mo

15. FILED Jan 1 1928 E W Ewing REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1927

17. I HEREBY CERTIFY, That I attended deceased from July, 1927, to Aug 4, 1927 that I last saw him alive on Aug 1, 1927, and that death occurred, on the date stated above, at 1 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs
23A 31
(duration) 1 yrs. — mos. — ds.
CONTRIBUTORY (SECONDARY) —
(duration) — yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

8 DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E W Ewing, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Masonic Grundy Co DATE OF BURIAL Aug 5 1927

20. UNDERTAKER Schook & son ADDRESS Spickards Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT RECORD

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Grundy Registration District No. 329 File No. 24121-B
 Township _____ Primary Registration District No. 4196 Registered No. _____
 City Spencer (No. _____) St. _____ Ward _____

2. FULL NAME Nell Hunt
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 13 - 1906

7. AGE YEARS MONTHS Days IF LESS than 1 day, _____ hrs. or _____ min.
20 11 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT _____
 (Address) _____

15. July 1, 1928 Ell Curry
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1927

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

ANS should state is very important.

RECORDED BY LAW

Information should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED.

SUPPLEMENTARY

S-24121-B