

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

Do not use this space.

11835

1. PLACE OF DEATH

County Saline
Township Marshall
City Marshall (No.)

Registration District No. 796
Primary Registration District No. 3038

File No.
Registered No. 52
St. Ward)

2. FULL NAME

Gilford Lee Hunt
(a) Residence. No. 595 W. Hunt 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male | White | Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 3 - 1928

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(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) Mo.

10. NAME OF FATHER

L. E. Hunt

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER

Mollie Stokes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

14.

INFORMANT L. E. Hunt
(Address) Marshall Mo

15.

FILED 3-6-28 Mrs. John H. McShire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5 - 1928

17. I HEREBY CERTIFY That I attended deceased from Mar 5 1928 to Mar 5 1928
that I last saw h. m. alive on Mar 5 1928 and that death occurred, on the date stated above, at 5:10 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cerebral Hemorrhage
(Traumatic)
1605 (duration) yrs. mos. ds. 3

CONTRIBUTORY (SECONDARY)

1605 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) L. E. Hunt M. D.

716 E. 19th (Address) Marshall

*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

Royal Oak Mar 6 - 1928

20. UNDERTAKER

ADDRESS

T. W. Campbell Marshall

WRITE CLEARLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. 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.

... should be ... A B should be ... PHYSICIANS should state ... exact statement of OCCUPATION ... very important

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Valerie Registration District No. 796 File No. _____
 Township _____ Primary Registration District No. 3038 Registered No. 5-2
 City Marshall (No. _____) St. _____ Ward _____

2. FULL NAME

Gilford Lee Hunt
 (a) Residence No. _____ St. _____ Ward _____ (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 M 4. COLOR OR RACE W 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) _____

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

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.

FILED 3-6-28 Mrs. John H. McQuire REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5 - 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cerebral hemorrhage (traumatic)
 (duration) yrs. mos. ds. 1
 CONTRIBUTORY Birth injury (duration) yrs. mos. ds. 1
 (SECONDARY) caused by instruments (duration) yrs. mos. ds. 1

18. WHERE WAS DISEASE CONTRACTED 161 B

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

N. B. - should be carefully supplied. AGE should be properly classified. Exact b. should be written in full state. This information is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-11-835