

MISSOURI STATE BOARD OF HEALTH

Do not use this space.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15246

1. PLACE OF DEATH

County *Lawrence*
Township *Jefferson*
City *Myrtle* (No. _____)

Registration District No. *470*
Primary Registration District No. *4283*

File No. _____
Registered No. *24*
St. _____ Ward _____

2. FULL NAME

Hanna Lee Hunter

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

Length of residence in city or town where death occurred *5* 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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 3 - 1923*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<i>5</i>	<i>9</i>	<i>21</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer) *X*

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Myrtle Mo*
(STATE OR COUNTRY)

10. NAME OF FATHER *Clarence Hunter*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Myrtle Mo*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Jane Bevington*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Myrtle Mo*
(STATE OR COUNTRY)

14. INFORMANT *Clarence Hunter*
(Address) *Myrtle Mo*

15. FILED *May 10 1929* REGISTRAR *W J Tuttle*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 25 1929*

17. I HEREBY CERTIFY, That I attended deceased from *April 12*, 1929, to *April 25*, 1929 that I last saw him *alive on April 26 1929* and that death occurred, on the date stated above, at *3:45 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastro enteric fever following influenza complicated by acute med. duration yrs. mos. *19* ds.

CONTRIBUTORY (SECONDARY) *10* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *at home*
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) *W. S. Shelton*, M. D.
, 19 (Address) *Myrtle Mo*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *So. J.* DATE OF BURIAL *4/26 1929*

20. UNDERTAKER *Geo Bon* ADDRESS *Myrtle*

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.

27 1929

