

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

Do not use this space.

36403

1. PLACE OF DEATH

County Buchanan Registration District No. 1001  
Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_  
City St. Joseph (No. State Hosp # 2) \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 1324  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence. No. State Hosp # 2 st. North Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 15 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs James F. Hunt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 7 1883

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min.  
46 2 10

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work mechanic  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN), St. Catherine (STATE OR COUNTRY) MO

10. NAME OF FATHER J. M. Hunt

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

12. MAIDEN NAME OF MOTHER Adaline Fuller

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

14. INFORMANT State Hosp # 2 records (Address) St. Joseph

15. FILED 18 1929 REGISTRAR John G. [Signature]

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 17 1929

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to Nov 17, 1929, that I last saw h. a alive on Nov 17, 1929, and that death occurred, on the date stated above, at 3 10/A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
General Paralysis of Insane  
83  
34 (duration) 3 yrs. 3 mos. 10 ds.

CONTRIBUTORY (SECONDARY) Syphilis (duration) - yrs. - mos. - ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH. \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical  
(Signed) A. H. [Signature] M. D.  
State Hosp # 2  
11-17, 1929 (Address) St. Joseph

\*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 Brookfield Mo. DATE OF BURIAL 11/19/ 1929

20. UNDERTAKER Fred D. Clark 5025 1/2 [Address] ADDRESS

WRITE PLAINLY, 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.

67-1820  
1826  
1827

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