

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

Do not use this space.

File No. **10802**

1. PLACE OF DEATH

County Mississippi
Township Opdyke
City Charleston (No. _____)

Registration District No. 569
Primary Registration District No. 5363

Registered No. _____
St. _____ Ward _____

2. FULL NAME

Homer Daniel Hunter

(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. 28 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 7, 1931

7. AGE YEARS MONTHS DAYS 78 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) Charleston
(STATE OR COUNTRY) _____

10. NAME OF FATHER Ed Hunter

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

12. MAIDEN NAME OF MOTHER Naunie Stewart

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

14. INFORMANT Ed Hunter
(Address) Charleston Mo. RFD, 4

15. FILED 3/7 1931 W. Marshall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/6 1931

17. I HEREBY CERTIFY, That I attended deceased from 3/4 1931, to 2/6 1931, that I last saw him alive on 2/14 1931, and that death occurred, on the date stated above, at 9:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Brainstem Rupture
101C
159

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

CONTRIBUTORY (SECONDARY) Brain Chites

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

18. WHERE WAS DISEASE CONTRACTED

at home
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) W. H. Sawyer M. D.

3/7 1931 (Address) W. H. Sawyer

*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 Rush Ridge **DATE OF BURIAL** 3/7 1931

20. UNDERTAKER Lane and Co. **ADDRESS** Charleston 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.

APR 24 1931

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

