

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.

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

Do not use this space.

NOV 27 1936

37314

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 2001
City Springfield (No. Barge Hospital)

File No. _____
Registered No. 836
St. _____ Ward _____

2. FULL NAME

Rev. Robert Elisha Hurt
(a) Residence, No. Springfield Park #9 St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 6 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Elsie Hurt</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 26, 1881</u>		
7. AGE	YEARS <u>54</u>	MONTHS <u>9</u>
	DAYS <u>5</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Evangelist</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation <u>9</u>
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lone Dell Mo.</u>	
MOTHER	13. NAME <u>Mose Hurt</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lone Dell Mo.</u>	
	15. MAIDEN NAME <u>Ava Lynn Williams</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lone Dell Mo.</u>	
17. INFORMANT (ADDRESS) <u>Mrs. Zelma Croner Park, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Greenlawn</u> DATE <u>Oct. 4, 1936</u>		
19. UNDERTAKER (ADDRESS) <u>H. C. Thiem Springfield, Mo.</u>		
20. FILED <u>10-1</u> 19 <u>36</u> <u>Chas. A. George</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-1-, 1936

22. I HEREBY CERTIFY, That I attended deceased from 9-29-, 1936 to 10-1-, 1936
I last saw him alive on 10-1-, 1936 at 8:45 P. m. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
Gangrenous Ruptured appendix
Date of onset 1936-9-29-

Other contributory causes of importance:
History of previous attacks.

Name of operation appendectomy Date of 9-30-36
What test confirmed diagnosis? P. Eys Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify _____
(Signed) J. D. Mueick, M. D.
(Address) Springfield, Mo.

