REC'D SEP 6 1939

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

28341
Do not use this space.

1. PLACE OF DEATH
(a) County JACKSON Registration District No. 399
(b) Township KAW Primary Registration District No. 1002 Registered No. 3343
(c) City KANSAS CITY (d) Street No. ST. JOSEPH'S HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 41 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
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2. PRINT FULL NAME Mrs. ALICE F. WOOD HUNT
(a) Residence, No. 5045 WALROND St.
(Usual place of abode, if no street address, write county or city) (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): MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND or~~ (OR) WIFE OF JOHN J. HUNT
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 21, 1884
7. AGE: YEARS 55 MONTHS 0 DAYS 2 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) WASHINGTON (STATE OR COUNTRY) MISSOURI

FATHER
13. NAME JOHN W. WOOD
14. BIRTHPLACE (CITY OR TOWN) FRANKLIN COUNTY (STATE OR COUNTRY) MISSOURI

MOTHER
15. MAIDEN NAME ABBIE FOSTER
16. BIRTHPLACE (CITY OR TOWN) WASHINGTON (STATE OR COUNTRY) MISSOURI

17. INFORMANT MR. JOHN J. HUNT (ADDRESS) 5045 WALROND
18. BURIAL, CREMATION, OR REMOVAL PLACE FOREST HILL DATE AUGUST 26, 1939
19. FUNERAL DIRECTOR (NAME) D.W. NEWCOMER'S SONS (ADDRESS) 1401-BRUSH CREEK BLVD.
20. FILED 8/24, 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) AUGUST-23, 1939
22. I HEREBY CERTIFY, That I attended deceased from Apr. 24th 39, to Aug. 23, 39
I last saw her alive on Aug 23rd 39. Death is said to have occurred on the date stated above, at 5:15 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Empyema of Gall-Bladder & Cholelithiasis.	
126	

Other contributory causes of importance:

Name of operation Cholecystectomy Date of 8/21/39
What test confirmed diagnosis? Was there an autopsy? Yes

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) James D. Smith M. D.
(Address) 318 Professional Bldg. Kansas City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed E. M. Calhoun

Licensed Embalmer No. 2506

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.