

Registration District No. 831 Primary Registration District No. 111 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Stoddard
 (b) City or town Buffinton, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Three fourths of Mile South
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: in hospital or institution _____ (Specify whether)
 In this community 1-year
 years, months or days

3. (a) PRINT FULL NAME Lucille Hunt
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband Hosea Hunt 6. (c) Age of husband or 46 years
 7. Birth date of deceased Oct. 13 1900
 (Month) (Day) (Year)

8. AGE: Years 39 Months 0 Days 18
 If less than one day _____ hr. _____ min.

9. Birthplace Augusta, Ark. Ark
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Will Jones
 13. Birthplace Miss.
 (City, town, or county) (State or foreign country)

{ 14. Maiden name Kathran Bennet
 15. Birthplace Miss.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
 (b) Address Buffinton, Mo.

17. (a) Burial (b) Date thereof Nov. 2, 39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Augusta Ark.

18. (a) Signature of funeral director Edwin Ellice
 (b) Address Sikeston Mo.

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Missouri (b) County Stoddard
 (c) City or town Buffinton, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. Three miles-south
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31, 1939
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Oct 31, 1939
 _____, 19____, to Oct 31, 1939
 that I last saw her alive on Oct 30, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Septic thromb Duration 3 days
 Due to Streptococcus infection
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death) 1150

Major findings: _____
 Of operations _____
 Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature A. M. Larnot M.D. (M. D. or other)
 Address Morehouse, Mo. Date signed Oct 31, 1939

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.

03
101
11
111
111

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 Oct 31

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

Signed Adrian Ellis

Licensed Embalmer No. 3869

P. O. Address Dixester, N

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

31397
Do not use this space.

1. PLACE OF DEATH
 (a) County Stoddard Registration District No. 839
 (b) Township Packland Primary Registration District No. 6101
 (c) City..... (d) Street No.....
 (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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lucille Hunt
 (a) Residence, No. Buffington no St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-13-1900

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>39</u>	<u>0</u>	<u>18</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House

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.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 31, 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1939, to Oct 31, 1939. I last saw her alive on Oct 30, 1939. 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:
Strep throat
Diphtheria
Streptococcus infection
 Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Arkansas

FATHER 13. NAME Will Jones
 14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Kathryn Bennett
 16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Buffington no

18. BURIAL, CREMATION, OR REMOVAL PLACE Augusta Ark DATE Nov 2, 1939

19. FUNERAL DIRECTOR (ADDRESS) Arden Ellise
Selection no

20. FILED 1-2-, 1940 J.P. Brandon
 Local Registrar.

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....
 If so, specify.....
 (Signed) J.M. Saross, M. D.
 (Address) Morehouse Rd

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

RECEIVED

Dis...

...

...

140-472
1-3