

DEC 18 1939

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

40068
Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 451
 (b) Township Eldorado Primary Registration District No. 5611a
 (c) City _____ (d) Street No. _____ 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Warner Hunt
 (a) Residence, No. Eldorado 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF no

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 2-39

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>7-</u>	<u>6-</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as Sawyer, bookkeeper, etc. at home

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) (STATE OR COUNTRY) Eldorado Mo

FATHER

13. NAME Warner Hunt

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Eldorado Mo

MOTHER

15. MAIDEN NAME Sarah Thomas

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no

17. INFORMANT Warner Hunt (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Rough Cemetery DATE Nov. 6 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Palmer Funeral Home
2 Lebanon Mo

20. FILED Dec 1 1939 Nara Cole Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-5 1939

22. I HEREBY CERTIFY, That I attended deceased from 11-2 1939 to 11-4 1939
 I last saw him live on 11-4 1939 Death is said to have occurred on the date stated above, at 7 P. m.
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia
fractured cranium
 Date of onset 1939

Other contributory causes of importance: no

Name of operation no Date of no
 What test confirmed diagnosis? Phys. Ex. 11/5/39 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 no
 (Signed) E. G. Carbou M. D.
 (Address) no

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.

Carbou

RECEIVED

District Health Officer No. 7,

District File Number 7-39-16 88-

Date Filed 12-12-39

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.....

Licensed Embalmer No.....

P. O. Address.....

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.