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.

JAN 8 1940

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

43107
Do not use this space.

1. PLACE OF DEATH
(a) County Clay / Registration District No. 198
(b) Township Fishing River / Primary Registration District No. 3011 Registered No. 158
(c) or City Excelsior Springs / (d) Street No. Veterans Administration Facility 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 0 yrs. 0 mos. 28 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 536 HUNTER, Durward B.
(a) Residence, No. 625 Lyons St. Brookfield, Mo.
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 9, 1871

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
68	10	23	

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Browning, Mo

FATHER
13. NAME Alfred M. Hunter
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.

MOTHER
15. MAIDEN NAME Agnes C. Batters
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada

17. INFORMANT (ADDRESS) Hospital Records

18. BURIAL, CREMATION, OR REMOVAL
PLACE Brookfield, Mo. DATE 12-3-39, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Claude Prichard Excelsior Springs, Mo.

20. FILED Dec 5, 1939 Mrs Rea McCracken
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 2, 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from 11-4-39, 19.... to 12-2-39, 19....
I last saw him alive on 12-2-39, 19.... Death is said to have occurred on the date stated above, at 11:55 p.m.
The principal cause of death and related causes of importance were as follows:

Coronary occlusion

Date of onset

Other contributory causes of importance:
Myocardial degeneration

Name of operation none Date of ....
What test confirmed diagnosis? .... 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? ....
If so, specify --
(Signed) W. A. GERMAN, MD, Clinical Director M.D.
(Address) Veterans Administration Facility Excelsior Springs, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1/5/40

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 co with the above constitutes grounds for revocation of license.)

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