

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

1675
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township 0 Primary Registration District No. 100
 (c) City St. Joseph (d) Street No. 2407 South 7th St 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. 2 mos. 26 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Sandra Lee Hurt
 (a) Residence, No. 2407 South 7th St 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) SINGLE

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) November 7, 1939

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>0</u>	<u>11</u>	<u>26</u>	

OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Infant</u>	11. Total time (years) spent in this occupation.
	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)	

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

FATHER 13. NAME Robert L. Hurt

14. BIRTHPLACE (CITY OR TOWN) Cameron, Mo (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Gladys Lurine King

16. BIRTHPLACE (CITY OR TOWN) Cameron, Mo (STATE OR COUNTRY)

17. INFORMANT Robert L. Hurt (ADDRESS) 2407 South 7th St

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Auburn DATE Jan 4, 1940

19. FUNERAL DIRECTOR (NAME) Tracy Barry Funeral Home (ADDRESS) 218 South 10th St

20. FILED Jan 4, 1940 H. J. Nestlebusch Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-3, 1940

22. I HEREBY CERTIFY, That I attended deceased from 12-28, 1939, to 1-3-1940, 1940

I last saw her alive on 1-3-1940 Death is said to have occurred on the date stated above, at 10 P. m.
 The principal cause of death and related causes of importance were as follows:

Bronchopneumonia
 Date of onset 12/28/39

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? E.T. exam 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

(Signed) Will W. Brown, M. D.

(Address) 222 Logan Bldg

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.

107a

190
3-2-29

STATE OF MISSOURI
DEPARTMENT OF HEALTH

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 John E. Rupp
Licensed Embalmer No. 3986
P. O. Address St. Joseph

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.

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CERTIFICATE OF DEATH

1675
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85-
(b) Township St. Joseph Primary Registration District No. 1001 Registered No. 6
(c) City St. Joseph (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

Sandra Lee Hurt
(a) Residence, 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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-3 1940

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to ... 19...
I last saw h... alive on ... 19... Death is said to have occurred on the date stated above, at ... m.

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

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
1 26

Broncho Pneumonia
Date of onset 10/14

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

Other contributory causes of importance:
no whooping cough or measles complications

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

13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Mar 12 1940 H. J. Nestlebaum 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
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? If so, specify (Signed) Wall M. Brown M. D. (Address) 222 Logan Bldg St. Joseph

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

SUPPLEMENTARY

