

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.

FILED FEB 15 1940

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

2245  
Do not use this space.

1. PLACE OF DEATH

(a) County Douglas <sup>3</sup> Registration District No. 95-6  
 (b) Township Clinton <sup>D</sup> Primary Registration District No. 6394 Registered No. \_\_\_\_\_  
 (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

531 Albert F. Hunter.  
 (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

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 24 1869

7. AGE YEARS 69 MONTHS 6 DAYS 16 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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) June 1939 11. Total time (years) spent in this occupation all of life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas Co Mo

FATHER 13. NAME John Hunter <sup>0</sup>

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown <sup>9</sup>

MOTHER 15. MAIDEN NAME unknown <sup>1</sup>

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Fred. Keenter Cabool Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Grove DATE June 12 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gaylord V. Elliott Cabool Mo

20. FILED June 15 1939 McAlicie Rankin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 10 1939

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 Sometime after 10. P.M.  
 The principal cause of death and related causes of importance were as follows:

Dropped dead, while Riding a mule. Suspected Heart failure.

Other contributory causes of importance: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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 \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased?   
 If so, specify \_\_\_\_\_  
 (Signed) C.W. Clinkingbeard we  
350 (Address) Cabool Mo Douglas Co

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**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.....

*Gaylord V. Elliott*

Licensed Embalmer No..... *2252*

P. O. Address..... *Carroll Mo.*

**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.**