

FILED MAR 8 - 1940

Registration District No. 413

Primary Registration District No. 5559.C.

Registrar's No. 9

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Cartersville
(c) Name of hospital or institution: Jasper County I.B. Hospital
(d) Length of stay: In hospital or institution 10 days
In this community _____ years, months or days

8. (a) PRINT FULL NAME 530 SAAC I. HUNT.
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Widowed 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 2 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Morgan County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____
MOTHER FATHER { 12. Name John W. Hunt
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Catherine
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. R. Kepple
(b) Address Cartersville

17. (a) Burial (b) Date thereof Feb 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cartersville
18. (a) Signature of funeral director W. H. City
(b) Address W. H. City

19. (a) FEB. 6. 40 (b) E. B. Hutchins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Cartersville
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 4th
year 1940 hour 8 minute 30 a. M.
21. I hereby certify that I attended the deceased from Dec 1, 1930 to Feb 4, 1940
that I last saw him alive on Feb 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Compensated
Due to from Cor Pulmonale
Due to _____
Other conditions (Include pregnancy within 3 months of death) 23

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) PO
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

28. Signature John B. Douglas (M. D. or other) MD
Address Cartersville Date signed 7/5/40
(Specify type of place) (e) Means of injury _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

50M-5-17-39
Rev. 5-17-39
I 11931

RECEIVED

District Health Officer No. 6,

District File Number 3410-667

Date Filed MAR 6 1940

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.