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MAY 13 1940
Registration District No. 422

Primary Registration District No. 557-24250

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Hillsboro Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 10 years (Specify whether _____)
years, months or days 36

3. (a) PRINT FULL NAME Glenn S. HUNTER

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 _____
7. Birth date of deceased Aug 13 1866 (Month) (Day) (Year)

8. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

8. AGE: Years 73 Months 7 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation 10

11. Industry or business _____

12. Name Unknown 18. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name Unknown 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant William R. Mitchem

(b) Address Hillsboro

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-26-40 (Month) (Day) (Year)

(c) Place: burial or cremation Green City Iowa

18. (a) Signature of funeral director Daniel J. Mahan (b) Address Des Moines Mo

19. (a) Apr 4-1940 (Date received local registrar) (b) Medred Perry (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jefferson
(c) City or town Hillsboro Mo (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25 year 1940 hour 2:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from Key holding Inquest March 25th to 25th 1940 that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Verdict of Jury was:
Due to Heart Attack:
Due to Acute Myocarditis

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy No.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury MI

23. Signature Frank Frazier, Coroner (M. D. or other)
Address Festus, Mo. Date signed 3/25/40

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Daniel J. Mahan

Licensed Embalmer No. 3783

P. O. Address Leicester, Ma.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *15-228*

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. *422*

Primary Registration District No. *4250*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Jefferson*
(b) City or town *Phillabaro*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

Glenn S. Hunter

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 _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased *August 12 1865*
(Month) (Day) (Year)

8. AGE:

Years *72* Months *7* Days *13*
If less than one day _____ hr. _____ min.

9. Birthplace *Johnson County, Iowa*
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born; how long in U. S. A.? _____ years.

20. DATE OF DEATH

MEDICAL CERTIFICATION

Month *Mar* day *25* year *1940* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature *Frank Frazer* (M. D. or other) _____
Address *Frank* _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

2.