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S. No. 2  
-11-10-39  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **17850**

Registration District No. **78**

Primary Registration District No. **4046-5115E**

Registrar's No. **8**

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

1. PLACE OF DEATH:

(a) County **Boone**  
(b) City or town **Columbia, (Missouri, Ind.)**  
(c) Name of hospital or institution: **No**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2**  
In this community **No**  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone**  
(c) City or town **Columbia "Rural"**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Rockport Pl-**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **James Richard Hunt 530**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Baby**

6. (b) Name of husband or wife **Baby** 6. (c) Age of husband or wife if alive **6** years

7. Birth date of deceased **April 18 1940**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**X** **X** **8** hr. \_\_\_\_\_ min.

9. Birthplace **Boone Co Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Baby**

11. Industry or business **Baby**

12. Name **Charles J. Hunt**

13. Birthplace **Boone Co Mo**  
(City, town, or county) (State or foreign country)

14. Maiden name **Ruth Drane**

15. Birthplace **Boone Co Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles J. Hunt**

(b) Address **Rockport Mo Pl.**

17. (a) **Burial** (b) Date thereof **April 27 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Locust Grove Midway**

18. (a) Signature of funeral director **R. Wilcox 70**

(b) Address \_\_\_\_\_

19. (a) **5-14-1940** (b) **May M. Anger**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **26<sup>th</sup>**  
year **1940** hour **3.45** minute **4** M.

21. I hereby certify that I attended the deceased from **April 16 - 1940** to **April 25 - 1940**; that I last saw him alive on **April 23 - 1940**; and that death occurred on the date and hour stated above.

Immediate cause of death **Bacter. Enteritis** Duration **7-10-40**

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 **A. E. Spingell** (M. D. or other) \_\_\_\_\_

Address **Rockport Mo** Date signed \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

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.**