

No. 2
11-10-39
1-17-39
I X21492

Registration District No. 446 Primary Registration District No. 4264 State File No. _____ Registrar's No. 34

1. PLACE OF DEATH:
(a) County Knox
(b) City or town Novelty
(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 9.26 years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Cora Bell Hunter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
7. Birth date of deceased Jan-12-1862 (Month) (Day) (Year)

8. AGE: - Years 78 Months 4 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Home keeper

11. Industry or business _____
12. Name Mary W. Hunter
13. Birthplace up up (City, town, or county) (State or foreign country)
14. Maiden name Mary C. May
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Carben W. Hunter
(b) Address Novelty

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May-17-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Novelty, Mo.

18. (a) Signature of funeral director Keith Hudson
(b) Address Edina Missouri

19. (a) May 20 1940 (Date received local registrar) (b) Mrs. C. M. Smith (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Knox
(c) City or town Novelty (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 May day 15 year 1940 hour 7 PM minute 25 P. M.
21. I hereby certify that I attended the deceased from May 5 1940, to May 15 1940 that I last saw her alive on May 15 1940 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction
Due to myocarditis and urmic poisoning
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? 395 (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature E. O. Hudson D.D. (M. D. or other) 3
Address Novelty Mo Date signed May 16 1940

Duration May 5 to May 15 1940
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

922

RECEIVED

District Health Officer No. 10

District File Number 6-40-1192

Date Filed JUN 11 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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Missou

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. 18814
Registrar's No. 34

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 446

Primary Registration District No. 4264

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

1. PLACE OF DEATH:

(a) County Boone County
(b) City or town Novelty
(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 Cara Bell Hunter

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

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

8. AGE: Years 78 Months 4 Days 3 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (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

MEDICAL CERTIFICATION

20. DATE OF DEATH _____ Month May day 15 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 myocardial insufficiency

Due to myocarditis + uremia

Due to poisoning 9371

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

Major findings: # Had not attended patient
Of operations n. m. o.

Of autopsy _____

PHYSICIAN
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) _____

(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) Means of injury _____

23. Signature E. O. Holman (of other) _____

Address Novelty _____ Date signed _____

SUPPLEMENTARY

S-18814