

18835

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 47

Registration District No. 461

Primary Registration District No. 3024

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Luxington
(c) Name of hospital or institution: W. 12th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
(c) City or town Luxington
(If outside city or town limits, write "RURAL")
(d) Street No. N 12th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
year 1940 hour 11 minute P. M.
21. I hereby certify that I attended the deceased from not at all
_____ 19____ to _____ 19____;
that I last saw him alive on May 5 _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary arteriosclerosis
Due to Chronic Endocarditis myocardium
Due to _____

Duration

Other conditions 92 N
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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? _____

890
While at work _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Luxington MO Date signed 5/8/40

3. (a) PRINT FULL NAME TAYLOR SAMSON HUNTER

3. (b) If veteran, name war _____ 3. (c) Social Security No. 485-09-737

4. Sex ma 5. Color or race colored 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mrs T.S. Hunter 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased July 6 1899
(Month) (Day) (Year)

8. AGE: Years 50 Months 9 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation Janitor

11. Industry or business _____

12. Name Robert Hunter

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

14. Maiden name Emma Bates

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

16. (a) Informant's own signature M. S. Hunter
(b) Address Luxington MO

17. (a) Burial (b) Date thereof May 8 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Luxington MO
18. (a) Signature of funeral director [Signature]
(b) Address Luxington MO
19. (a) May 8, 1940 (b) Delia Bates
(Date received local registrar) (Registrar's signature)

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-13-40

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..... *Garret J. Gumpel*
Licensed Embalmer No. *3275*
P. O. Address..... *Lexington*

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.