

FILED JUN 6 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

19275
Do not use this space.

1. PLACE OF DEATH *Platte* 2
 (a) County *Platte* Registration District No. *698*
 (b) Township *Weston* 0 Primary Registration District No. *4420* Registered No. _____
 (c) City *Weston* (d) Street No. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME *530 Orlia Hunt*
 (a) Residence, No. *Weston* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Wm Hunt*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 14 1851*
 7. AGE YEARS *89* MONTHS *2* DAYS *10* If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. *at home*
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Gower Mo*
 FATHER 13. NAME *D. F. Pierce* 9
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *North Carolina* 1
 MOTHER 15. MAIDEN NAME *unknown*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *North Carolina*
 17. INFORMANT (ADDRESS) *Mrs Annie Schudler Weston mo*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Laurel Hill* DATE *May 1 1940*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J H Brill Weston mo*
 20. FILED *4/30 1940* *J H Brill* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April-29-1940*
 22. I HEREBY CERTIFY, That I attended deceased from *March 18-1940*, to *April-29-1940*.
 I last saw her alive on *April-29-1940* Death is said to have occurred on the date stated above, at *9 a.m.*
 The principal cause of death and related causes of importance were as follows:
Acute Cholecystitis Date of onset _____
 Other contributory causes of importance: *Intestinal infection*
 Name of operation *None* Date of _____
 What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury *✓*
 Nature of injury *✓*
 24. Was disease or injury in any way related to occupation of deceased? *No*
 If so, specify _____
 (Signed) *Lewis E. Calvert* M. D.
 (Address) *Weston, mo.* 628

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.

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RECEIVED
District Health Officer No. 11;
District File Number 640-828
Date Filed JUN 5 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19273-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 698

Primary Registration District No. 4420

Registrar's No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD
ROWENA MOORE

1. PLACE OF DEATH:
(a) County Platte
(b) City or town Wenton
(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.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Diza Hunt
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married divorced and
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 2 15 hr. min.

9. Birthplace..... (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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (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.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH Month Apr day 29
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 Acute Cholecystitis Duration.....

Due to..... 177
Due to.....

Other conditions Intestinal infection
(include pregnancy within 3 months of death)
Colon bacillus w

Major findings: origins
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?

While at work..... (Specify type of place)

(e) Means of injury.....

23. Signature Lewis C. Calvert (M. D. or other).....

Address Wenton..... Date signed.....

SUPPLEMENTARY

S-19275