

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

1934

Do not use this space.

1. PLACE OF DEATH *1*
 (a) County *Ray* Registration District No. *244*
 (b) Township *Richmond* Primary Registration District No. *3035* Registered No. *58*
 (c) City *Richmond* (d) Street No. *Richmond Hospital* St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred *530* *Richmond* *days* mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Roy Glenn Hunt*
 (a) Residence, No. _____ St. *Polo Mo.*
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF _____ (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 19 - 1916*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
24 *27*

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. *Farmer*
 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) *Ray Co. Mo.*

FATHER
 13. NAME *Frank Hunt*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *West Virginia*

MOTHER
 15. MAIDEN NAME *Bertha Newell*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *West Virginia*

17. INFORMANT *Chas. Hunt* (ADDRESS) *Polo Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Bethel* DATE *4-17*, 19*40*

19. FUNERAL DIRECTOR (NAME) *Alspaugh & Cowley* (ADDRESS) *Polo Mo.*

20. FILED *June 8*, 19*40* *Malcol Jackson* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 16*, 19*40*

22. I HEREBY CERTIFY, That I attended deceased from *4-15-40*, 19____, to *4-16-40*, 19____
 I last saw h. *m.* alive on *4-16-40*, 19____. Death is said to have occurred on the date stated above, at *3:22 a.m.*
 The principal cause of death and related causes of importance were as follows:
Acute myocarditis
diphtheria
 Date of onset _____

Other contributory causes of importance:
Pertussis or whooping cough
(streptococcus)

Name of operation *none* Date of _____
 What test confirmed diagnosis? *P.S.* 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) *F. M. Griffith*, M. D.
 965 (Address) *Richmond, Mo.*

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.

Date ~~File~~ 6-14-48
District File Number
District Health Officer No. 8
RECEIVED

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.