

146

RECEIVED

District Health Officer No. 2

District File Number 640-113

Date Filed 6/20/40

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 *Mariusz Popielny*

Licensed Embalmer No. 3242

P. O. Address *Chaffee Mo*

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.

There was no delivery or abortion in this case.
The deceased was in the 7th month of pregnancy.
No physician was consulted until afternoon of
woman's death. Certificate filled out according
to history given by the husband of the
deceased -

S- (21) - 19707
Isabella Gilbert Hunt
June 13 - 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Supplements
State File No. 19707

Registration District No. 814

Primary Registration District No. 6063

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Mt. Pleasant
(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
In this community (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME

Idella Gilbert Hunt

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 6 day 13 year 1940 hour minute M.

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 W

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 40 Months 8 Days 15 If less than one day 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death Convulsions
Serebia

Due to

Due to over

Other conditions (Include pregnancy within 3 months of death)

Major findings nephritis pregnancy 146
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 J. P. Bryan (M.D. or other) Address Boston Mo Date signed

Duration
PHYSICIAN
Underline the cause of death which should be charged statistically.

SUPPLEMENTAL COPY