

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

REV. 6-17-30 I X19311

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20727
Registrar's No. 2344

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital #2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5-6-40-6-5-40
(Specify whether in this community, years, months or days) 18 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 2211 Lydia
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William M. Hunter 5310
 (b) If veteran, name war None (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 6 day 5
 year 40 hour 4 minute 25 A. M.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mary Hunter 6. (c) Age of husband or wife if alive Unk. 62 yrs
 7. Birth date of deceased: February 14, 1885
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 5-6- 1940, to 6-5- 1940
 that I last saw h. 6 alive on 5 1940
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>3</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death: Cerebral Apoplexy
Arterio-sclerosis
 Due to _____
 Due to _____

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

Other conditions: _____
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: _____
 Of autopsy: _____

10. Usual occupation None

MOTHER FATHER
 11. Industry or business _____
 12. Name Richard Hunter
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Record Clerk
 (b) Address General Hospital #2

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? _____

17. (a) burial (b) Date thereof 6/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Highland

While at work? _____ Means of injury _____
 23. Signature [Signature] (M. D. or other) _____
 Address Gen. Hosp. #2 Date signed 5-7-

18. (a) Signature of funeral director Matkins Bros.
 (b) Address 1729 Lydia
 19. (a) June 8, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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

Isaac Jerome Mallove

Licensed Embalmer No. *3994*

P. O. Address *11206 23rd St*

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.