

Registration District No. **318**

Primary Registration District No. **2001**

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

1. PLACE OF DEATH:

**GREENE**  
**Springfield**

(a) County  
(b) City or town  
(c) Name of hospital or institution: **Bronze Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 day**  
In this community **1 day**  
years, months or days

3. (a) PRINT FULL NAME **Hattie Lacy Hurt**

3. (b) If veteran, name war **700** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **H. T. Hurt** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **July 31 1883**  
(Month) (Day) (Year)

8. AGE: -Years **1 57** Months **0** Days **19** If less than one day hr. min.

9. Birthplace **Wheatland - Hickory Co - Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **Joseph R. Johnston**  
13. Birthplace **Copper County - Missouri**  
14. Maiden name **Sarah Alice Hunt**  
15. Birthplace **Shelby County - Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. J. S. Johnston**  
(b) Address **Wheatland, Mo**

17. (a) **Removal** (b) Date thereof **8-18-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BOONVILLE, MO.**

18. (a) Signature of funeral director **H. H. LOMMEYER**

(b) Address **SPRINGFIELD, MO**

19. (a) **Aug. 18, 1940.** (b) **W. C. Hurdley**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Copper Co**  
(c) City or town **Boonville, Mo - R.R. 1**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **R.R. 1**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **18**  
year **1940** hour **7** minute **15 a.m.**

21. I hereby certify that I attended the deceased from **Aug 16**  
19**40**, to **Aug 18**, 19**40**  
that I last saw her alive on **8-18-**19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Typhoid Fever** Duration **2 wks**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy **None**

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? **98 ft**  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **Joseph L. Johnston** (M. D. or other) Address **Springfield, Mo** Date signed **10-19-40**

**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 Walter E Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield 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.**

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