

S. No. 2
-11-10-39
5-17-39
-I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35142

State File No. _____

Registration District No. 218

Primary Registration District No. 3015

Registrar's No. 117

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

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Dr. Alex van Ravenswaay Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 Hours.
(Specify whether)

In this community 13 Years
years, months or days

3. (a) PRINT FULL NAME William Thomas Hurt.

8. (b) If veteran, name war. -----

3. (c) Social Security No. 495-12-3962

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Myrtle Hixon Hurt.

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Jan. 36th 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>9</u>	<u>3</u>	hr. _____ min.

9. Birthplace Cooper County, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Employee in Pipe Works.

11. Industry or business Cob Pipe Factory.

12. Name Acrey Hurt.

13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Matilda Rickard.

15. Birthplace Virginia.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. T. Hurt.

(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof Oct. 29th/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove Cem.

18. (a) Signature of funeral director Goodman Waller

(b) Address Boonville, Mo.

19. (a) 10-29-40 (b) De Cooper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

(c) City or town Boonville.
(If outside city or town limit, write "RURAL")

(d) Street No. 317 E. Spring St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? ----- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 36th year 1940 hour 2 minute _____ A. M.

21. I hereby certify that I attended the deceased from Oct 27, 1940, to Oct. 28, 1940
that I last saw him alive on Oct. 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 1/2 hrs.

Due to Hypertensive C.V. Disease

Due to _____

Other conditions 15/12
(Include pregnancy within 3 months of death)

Major findings:
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? 127

23. Signature Hubrey H. Wells (Specify type of place) _____
(Specify type of place) (b) Means of injury

Address Boonville, Mo. Date signed 10-29-40

AUG 4 1949

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-6-49

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 G. F. Boller

Licensed Embalmer No. 3067

P. O. Address Rowells M

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.