

Registration District No. 810

Primary Registration District No. 4488

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Scottland
(b) City or town Memphis
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community most all her life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah Hunt

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Apr 23 1855
(Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Noble Co Ohio (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeping

11. Industry or business _____

12. Name Geo Hunt

13. Birthplace Noble Co Ohio (City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant B. C. Durnal

(b) Address Memphis Mo

17. (a) Burial (b) Date thereof Sept 1-4 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director E. E. Parrish

(b) Address Memphis Mo

19. (a) 9-1-41 (b) E. E. Parrish (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scottland
(c) City or town Memphis (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30 year 1941 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from Apr 1 1941 to Aug 30 1941; that I last saw her alive on Aug 19 1941 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Chronic Myocarditis

Due to Malnutrition
Arteriosclerosis

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 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? _____ (Specify type of place)

While at work? _____ (a) Means of Injury _____

23. Signature E. E. Parrish (M. D. or other) Address Memphis Mo Date signed 9-1-41

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

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

RECEIVED

District Health Officer No. 10
District File Number 9-4-1702

Date Filed SEP 18 1941

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.