

FILED APR 28 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

15713

## 1. PLACE OF DEATH:

(a) County Saline  
 (b) City or town Slater Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
400 N. Broadway  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 39 years (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME Olive Upson Hunter3. (b) If veteran,  
name war X3. (c) Social Security  
No. 487 01 57714. Sex Female5. Color or  
race Wh6. (a) Single, widowed, married,  
Widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased June 15 1887  
(Month) (Day) (Year)8. AGE: Years 54 Months 9 Days 20  
If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Troy Mo  
(City, town, or county) (State or foreign country)10. Usual occupation Sewing machine operator11. Industry or business Rice Stix Garment Factory12. Name Wilbur Upson13. Birthplace Ohio  
(City, town, or county) (State or foreign country)14. Maiden name Almarinda Nichols15. Birthplace Mo  
(City, town, or county) (State or foreign country)16. (a) Informant Fern Hill(b) Address Slater Mo.17. (a) Burial (b) Date thereof 4 7 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Slater Mo.18. (a) Signature of funeral director HILL. BROTHERS(b) Address Slater Mo.19. (a) 4-8-1942 (b) Mrs John Giger  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 99  
 (c) City or town Slater 2  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 400 N. Broadway  
 (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country X

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5  
year 1942 hour 7 minute 45 A.M.21. I hereby certify that I attended the deceased from  
March 19 39 to April 5 1942  
that I last saw her alive on April 5 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Pneumonia-hypostatic 3 daysDue to Cerebral Hemorrhage 6 mo.Due to Hypertension POther conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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)  
(b) Means of injury \_\_\_\_\_23. Signature C. M. Burney, M.D.Address Slater, Mo. Date signed 5-6-42

WRITE PLAINLY—USE UNFADING BLACK INK

12/1

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-27-42

---

**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 Edgar Moore

Licensed Embalmer No. 4187

P. O. Address Slater Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 799

Primary Registration District No. 4479

Registrar's No.

1. PLACE OF DEATH:

(a) County: Saline  
(b) City or town: Saline  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Olive U. Hunter

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: F 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: June 15 1887  
(Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ min.)

9. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

MOTHER FATHER  
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) \_\_\_\_\_ (b) Date thereof: \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day \_\_\_\_\_ Year 1942 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

hypostatic pneumonia  
Due to this is due to a  
Due to hypostatic condition  
Other condition of the lungs - neither  
(Include presence within 3 months of death) lobar nor bronchial

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
10911

Duration

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?

23. Signature C. W. Suray \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

1942

S-15713