

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

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

33831

State File No.

4359

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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:
3217 Cleveland
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Sherman C. Hunt

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

4. Sex Male 5. Color or Race Wh 6. (a) Single, widowed, married, divorced No Record

6. (b) Name of husband or wife No Record 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased No Record
(Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace No Record 9
(City, town, or county) (State or foreign country)

10. Usual occupation No Record

11. Industry or business _____
 MOTHER FATHER { 12. Name No Record
 { 13. Birthplace No Record 9
(City, town, or county) (State or foreign country)
 { 14. Maiden name No Record
 { 15. Birthplace No Record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Belle Bingham
 (b) Address 3217 Cleveland
K. C. Western Dental College
(Burial, cremation, or removal) (c) Date thereof Oct 12 43
(Month) (Day) (Year)

18. (a) Signature of funeral director [Signature]
 (b) Address 7406 Wornall Rd

19. (a) 10-13-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State J. MO. KAN. (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 3217 Cleveland
(If rural, give location)
 (e) Citizen of foreign country? No Record (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 9
 year 43 hour 4:35 P M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Mouth
 Duration _____

Due to 45c

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

Major findings: Of operations _____
 Of autopsy [Signature]
 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? _____

While at work _____
(Specify type of place) (e) Means of injury _____
 23. Signature [Signature] (M.D. or other) _____
 Address [Signature] Date signed 10/17/43

367 (Licensed Embalmer's Statement on Reverse Side)

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 *Harold Roe*.....

Licensed Embalmer No. *2810*.....

P. O. Address *H. C. 2nd*.....

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, fact should be so stated above.