

No. 2
9-4-41
17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38634

State File No.

FILED DEC 6 1943
Registration District No. 3039

Primary Registration District No. 3039

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Marceline
(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 years, months or days) 49 years

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln

(c) City or town Marceline
(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 Louisa Jane Hunter

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23
year 1943 hour 8 minute 50 P.M.

21. I hereby certify that I attended the deceased from April 28 1940 to Nov 23 1943
that I last saw her alive on Nov 23 1943
and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Shadrach Hunter

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased May 9 1867
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage

Duration 2 days

8. AGE: Years 86 Months 6 Days 15
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

9. Birthplace Westville Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy _____

MOTHER { 11. Industry or business _____

FATHER { 12. Name John McKee

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

14. Maiden name Rachel Olinger

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

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) Means of injury gall

23. Signature James M. Laughlin (M. D. or other) _____
Marceline Mo Date signed 11/24/43

Address _____

16. (a) Informant William Hunter

(b) Address Rock Springs Wyo

17. (a) burial (b) Date thereof Nov
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Olivet

18. (a) Signature of funeral director James M. Laughlin

(b) Address Marceline Mo

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

1304 (Licensed Embalmer's Statement on Reverse Side)

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

MAY 2 1945

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 *Mrs. Blanche M. Raughter*
Licensed Embalmer No. *19091*
P. O. Address *Marseline 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, fact should be so stated above.

State File No. See
Registrar's No. 8

Registration District No. 285 Primary Registration District No. 3039

1. PLACE OF DEATH: Living
(a) County Livingston
(b) City or town Marceline
(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 _____ (Specify whether _____)
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 Louisa Jane Hunter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May Year 1943
year 1943 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 _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: May 9
(Month) (Day) (Year)
8. AGE: Years 86 Months _____ Days _____ If less than one day _____ min. _____

9. Birthplace Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 1-26-43 (b) P. J. Patrick
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

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

38634

MAY 17 1944