

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FILED MAR 9 1944  
Registration District No. **10023**

Primary Registration District No. **4474**

Registrar's No. **6**

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

1. PLACE OF DEATH

(a) County Saline  
(b) City or town Sweet Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Laisy Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution ✓ (Specify whether  
Three months)  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Sarah B. 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 Married  
6. (b) Name of husband or wife John L. Hunt 6. (c) Age of husband or wife if alive 86 years  
7. Birth date of deceased August 27, 1862  
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House Wife at Home

11. Industry or business Joseph Gorman

12. Name Joseph Gorman  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Laura J. Middle  
15. Birthplace Saline Co Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant See Report

(b) Address Sweet Springs Mo  
17. (a) Burial (b) Date thereof 2-29-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery Jessettown

18. (a) Signature of funeral director Jessettown  
(b) Address Sweet Springs Mo

19. (a) Feb. 27, 44 (b) Mrs Vera Hoffmann  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Sweet Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 130 Laisy Ave  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27  
year 1944 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 20,  
1944 to Feb 27, 1944  
that I last saw her alive on Feb 26, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 3 da.

Due to Acute Bronchitis 1 wk

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy none

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 0

23. Signature A. H. Ringrose (M. D. or other) \_\_\_\_\_  
Address Sweet Springs, Mo Date signed 2-28-44

RECEIVED

District Health Officer No. 8,

District File Number

3-8-44

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.....

*Jesse H. Army*

Licensed Embalmer No.....

2214

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, fact should be so stated above.