

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 31 1944
Registration District No. 776

Primary Registration District No. 6025

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RT. 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francois
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether July)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Pinckney Luther Hunt

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Gora Viola Wood Hunt

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

7. Birth date of deceased May 26 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

85 1 17 _____ hr. _____ min.

9. Birthplace Farmington RT. 1 Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name John Hunt

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

14. Maiden name Lucinda Alexander

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

16. (a) Informant Wood Hunt

(b) Address Farmington, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13 44
(Month) (Day) (Year)

(c) Place: burial or cremation K of P Cemetery

18. (a) Signature of funeral director _____

(b) Address Farmington, Mo

19. (a) 7-14-44 (Date received local registrar) (b) James John (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. Farmington RT. 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13
year 1944 hour 4 minute AM

21. I hereby certify that I attended the deceased from July 1, 1944 to July 13, 1944
that I last saw him alive on July 11, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to General Arteriosclerosis

Chronic Prostatitis

Due to _____

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

Major findings: 137a

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 _____

Signature R Applebee (M. D. or other)

Address Farmington Date signed 7-13-44

1373

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4
District File Number 744-4101
Date Filed 7-28-44

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..... *C. Hozean*
Licensed Embalmer No. 4084
P. O. Address Laramie, Wyo.

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.