

FILED DEC 17 1944

Primary Registration District No. 3035

Registrar's No. 71

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Livingston, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
19th Taylor  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 9 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette  
(c) City or town Livingston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 19th Taylor  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LETA INEZ HURT

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

4. Sex Female 5. Color or race W  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Estell Hurt  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 1904  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
40 9 4 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name Arch Nicholson  
13. Birthplace Clay Co. Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Ida B. Jackson  
15. Birthplace Clay Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Estell Hurt

(b) Address Livingston, Mo

17. (a) Removal (b) Date thereof 11-25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kearney, Mo

18. (a) Signature of funeral director Forest Orkney  
(b) Address Livingston, Mo  
19. (a) Nov-25-44 (b) Mrs. Fred Schwab  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23  
year 1944 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 28, 1944 to Nov 23, 1944

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Retropneumal Malaryas  
Saxpoma

Due to Sm. Reno

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

Other conditions ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
(Include pregnancy within 3 months of death)

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

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 D. Orkney (M. D. or other) \_\_\_\_\_  
Address Lafayette, Mo Date signed 11/24/44

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

12-9-47

808

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

*W. McKean*

Licensed Embalmer No.

2983

P. O. Address

*Levington Mo*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 174

Primary Registration District No. 2035

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Lexington  
(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)

3. (a) PRINT FULL NAME Leta J. Hunt

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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 19 1901 (Month) (Day) (Year)

8. AGE: Years 40 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

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

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

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

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

Metastatic carcinoma - Abdomen

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

Due to H & h

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 \_\_\_\_\_

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

**SUPPLEMENTARY**

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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