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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 3 1945
8

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5529

Registration District No. _____

Primary Registration District No. 3006

Registrar's No. 22

10
2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Boone
 (b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Woyes Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)
 In this community Lifetime

8. (a) PRINT FULL NAME Margaret June Hunt
8. (b) If veteran, name war _____ **3. (c) Social Security No.** 497-16-3240

4. Sex Female **5. Color or race** W. **6. (a) Single, widowed, married, divorced** Widowed
6. (b) Name of husband or wife S. C. Hunt **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased 2 - 10 - 1880
(Month) (Day) (Year)

8. AGE: Years 64 Months 11 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name William A Bright
13. Birthplace Callaway Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Sally Carter Paright
15. Birthplace Boone Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant J. Robertson
(b) Address Columbia, Mo.

17. (a) Burial **(b) Date thereof** 1-27-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Allen Funeral Service
(b) Address Columbia, Mo.

19. (a) 1-27-1945 **(b) Edna H. Barber**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Boone 10
 (c) City or town Columbia ?
(If outside city or town limits write "RURAL")
 (d) Street No. 804 Canley 4
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? No 8 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25 year 45 hour 7 minute 30 M.

21. I hereby certify that I attended the deceased from Jan 22, 1945, to Jan 25, 1945
 that I last saw her alive on Jan 25, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia 4 days
 Duration

Due to _____

Due to _____

Other conditions Purpura + Multiple septic joints 4 days
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 77A

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? _____

23. Signature [Signature] (M. D. or other) MD
 Address Columbia Date signed 1/20/45

RECEIVED
District Health Officer No. 5
District File Number
Date Filed 3-2-45

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 Frank Lanning
Licensed Embalmer No. 4132
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, above space should be left blank.