

S. No. 2
M-5-43
5-17-39
I X36671

State File No. _____

FILED MAR 10 1945

Registration District No. 155

Primary Registration District No. 5578

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2025 Utica Ave. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 years (years, months or days)

3. (a) PRINT FULL NAME Harry H. Huntoon

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Minnie May Huntoon 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased July 8, 1861 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	6	27	hr. min.

9. Birthplace Newport New Hampshire (City, town, or county) (State or foreign country)

10. Usual occupation retired carpenter

11. Industry or business _____

12. Name Ransom Huntoon

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

14. Maiden name Elizabeth Thorpe

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

16. (a) Informant Minnie May Huntoon

(b) Address 2025 Utica Ave Joplin Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (Month) (Day) (Year)

(c) Place: burial or cremation Seneca Cemetery

18. (e) Signature of funeral director: Hurlbut Und. Co; (b) Address Joplin Mo.

19. (a) Feb. 7, 1945 (Date received local registrar) (b) M. C. Lillie Sage (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(d) State Missouri (b) County Jasper 49
(e) City or town Joplin (If outside city or town limits, write "RURAL")
(d) Street No. 2025 Utica Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 4, day 1945
year 7-25 P.M. minute M.

21. I hereby certify that I attended the deceased from Jan 26, 1944 to Feb 4, 1945 that I last saw him alive on Feb 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

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) Date signed 2/7/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1140

45-2-176

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.....
Licensed Embalmer No. 959
P. O. Address Joplin 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.

Registration District No. 15-51

Primary Registration District No. 5578

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

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin - Joplin Turp.
(c) Name of hospital or institution Royal Heights - 3025 Utica
(d) Length of stay: In hospital or institution. _____ (Specify whether)

In this community _____ years, months or days (Huntton)

3. (a) PRINT FULL NAME Harry H. Huntton
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 M

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

7. Birth date of deceased July 8
(Month) (Day) (Year)

8. AGE: Years 83 Months 6 Days 10 If less than one day _____ min.

9. Birthplace _____ (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 _____ (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb 7, 1945 (b) Mrs. Lillie Lagle
(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 Feb day _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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

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

60381