V. S. No. 2
00M—5-43
Rev. 5-17-39
1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29719

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3912

18
3
8

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution K. C. General Hospital No. 1 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days (Specify whether

In this community 52 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL")

(d) Street No. 1800 Pendleton 8 (If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country ----

3. (a) PRINT FULL NAME Amanda F. Rose Hunt

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Mr. FRANK Hunt

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

7. Birth date of deceased July (Month) 26 (Day) 1864 (Year)

8. AGE: Years 81 Months 1 Days ~~23~~ 22 If less than one day hr. min.

9. Birthplace UNKNOWN (City, town, or county) Pennsylvania (State or foreign country)

10. Usual occupation Housewife

11. Industry or business AT-HOME

FATHER
12. Name CHARLES Koch
13. Birthplace UNKNOWN (City, town, or county) PENNSYLVANIA (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace (City, town, or county) UNKNOWN (State or foreign country)

16. (a) Informant MR SYLVANUS KULP OTT

(b) Address 1800 PENDLETON AVENUE

17. (a) CREMATION (Burial, cremation, or removal) (b) Date thereof SEPT. 21-1945 (Month) (Day) (Year)

(c) Place: ~~burial~~ or cremation D.W. NEWCOMER'S SONS

18. (a) Signature of funeral director D.W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 9-21-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 18 year 1945 hour 3 minute 30 A M.

21. I hereby certify that I attended the deceased from September 16 1945 to September 18 1945 that I last saw her alive on September 18 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death acute cerebral and pulmonary edema	
Due to cardiac decompensation	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

95C 2

Major findings: Of operations

Of autopsy see above

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Wm W. Hartman (M. D. or other)

Address Act. Med. Dir. K. C. General Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Emile M Calhoun

Licensed Embalmer No. 3506

P. O. Address Kc 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.