

FILED DEC 6 1945

State File No. _____

Registration District No. 50

Primary Registration District No. 5102

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Benton Warsaw Mo

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

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

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

In this community 25 yrs years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Benton

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

(d) Street No. Rural Fristoe Twp
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Andrew Jefferson Hunsaker

3. (b) If veteran, name war No

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 17 day Nov year 1945 hour 12 55 minute _____ P.A.M.

21. I hereby certify that I attended the deceased from Oct 2 1945 to Nov 17 1945 and that death occurred on the date and hour stated above.

4. Sex Male race White

5. Color or race White

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

6. (b) Name of husband or wife Ellen

6. (c) Age of husband or wife if alive 88 years (Day) (Year)

7. Birth date of deceased: Sept 2 1956 (Month) (Day) (Year)

Immediate cause of death Acute Nephritis

Due to Senility

Other conditions _____

(Include pregnancy within 3 months of death)

8. AGE: Years 89 Months 2 Days 20

If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Andrew Jackson Hunsaker

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

14. Maiden name Lucy Hunsaker

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

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 _____

16. (a) Informant Boy O Hunsaker

(b) Address Warsaw Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/45 (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Quane

(b) Address Warsaw Mo

19. (a) 11-17-45 (Date received local registrar) (b) Joe A Logan (Registrar's signature)

23. Signature Reel (M. D. or other)

Address Warsaw Mo Date signed 11/19/45

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

Date

11-45-11.5.0
12-4-45-

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

Wesley Ewing

Licensed Embalmer No.

3847

P. O. Address

Sedalia 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. 30

Primary Registration District No. 5102

1. PLACE OF DEATH:

(a) County Benton
(b) City or town Fristal Imp Rural
(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 Andrew J. Hunsaker

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 _____

7. Birth date of deceased Sept (Month) 2 (Day) 1945 (Year)

8. AGE: Years 89 Months 2 Days _____ If less than one day _____ hr. _____ 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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(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 _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 Acute Nephritis Duration _____

Due to Acute Influenza

Due to _____

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

Major findings: Of operations _____

Of autopsy 33b

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 Heckhart (M. D. or other) _____ Address Wasserman Date signed 12-12-45

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.

30570