No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

FILED JUL 22 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

22753

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 775

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution Missouri Methodist Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 hrs 0 (Specify whether

In this community 3 hrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth 113

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

(d) Street No. Grant City 1 (If rural, give location)

(e) Citizen of foreign country? no (~~Yes or No~~)

If yes, name country

3. (a) PRINT FULL NAME James Ralph Hunt

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex M D

5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 18 (Day) 1945 (Year)

8. AGE: Years 0 Months 10 Days 18 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business ✓

FATHER
12. Name Jubal Ralph Hunt
13. Birthplace Worth Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Cyral Frances Hensley
15. Birthplace Grant City (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs Jubal Hunt

(b) Address Grant City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-6-46 (Month) (Day) (Year)

(c) Place: burial or cremation Redding, Iowa

18. (a) Signature of funeral director Arch L. Burfee

(b) Address Grant City, Mo.

19. (a) July 8, 1946 (Date received local registrar) (b) [signature] (Registrar's signature) By V.N.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1946 hour 1 minute 30 P M.

21. I hereby certify that I attended the deceased from 11 AM July 6, 1946 to 1:30 PM July 6, 1946 that I last saw him alive on July 6, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Salicylate Poisoning given by baby sister	1 day
Due to Producing an Acidosis	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W Roger Moore (M. D. or other)

Address St Joseph, Mo Date signed 7/6/46

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(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 Jack O. Trimble

Licensed Embalmer No. 3252

P. O. Address Grant City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 7[illegible]

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(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)

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

3. (a) PRINT FULL NAME James R. Hunt

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 18 1945
(Month) (Day) (Year)

8. AGE: Years | Months 10 | Days 18 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 6 year 1946 hour 1 minute 30 P M.

21. I hereby certify that I attended the deceased from July 6, 1946 to July 6, 1946 that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Salicylate (aspirin) poisoning	26 hrs
Due to	
Due to Given aspirin by child by mistake	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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) Given aspirin by small sister by mistake

(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

23. Signature U Roger Moore MD (M. D. or other)

Address St Joseph Mo Date signed 7/26/46

SUPPLEMENTARY

2/6/16

22753