

No. 2
2-43
17-39
35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 2 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36552**

Registration District No. **101**

Primary Registration District No. **4173**

Registrar's No. **67**

1. PLACE OF DEATH:

(a) County **Douglas**
(b) City or town **Ava**
(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 **Horace M. Curnutt**

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

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

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

7. Birth date of deceased **September 3, 1867**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 2 7 hr. min.

9. Birthplace **Pike County, Ind.**
(City, town, or county) (State or foreign country)

10. Usual occupation **County officer**

11. Industry or business **Retired**

12. Name **James M. Curnutt** Tenn.

13. Birthplace **Franklin Housley** Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name _____ Tenn.

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

16. (a) Informant **J. E. Lunny**

(b) Address **Ava, Missouri**

17. (a) **Burial** (b) Date thereof **11-18-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ava**

18. (a) Signature of funeral director **Clinkingbeard Funeral Home**
(b) Address **Ava, Missouri**

19. (a) **11-21-46** (b) **Wesley Bushman**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Douglas** **34**
(c) City or town **Ava** **1**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **15**
year **1946** hour **7** minute _____ A. M.

21. I hereby certify that I attended the deceased from **7-15-46**
19____, to _____, 19____

that I last saw him alive on **11-15**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to **Acute Coronary Occlusion** **Subst**

Due to **Chronic Myocarditis** **2%**

Due to _____

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

Major findings: Of operations **ASD**

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 **11**

23. Signature **Wesley Bushman** (M. D. or other) _____
Address **Ava** Date signed **11-15-46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

84

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 1146-1189

Date Filed NOV 29 1946

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..... *W.B. Hutchison*.....

Licensed Embalmer No. 3431

P. O. Address..... *Oran MD*.....

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. 101 Primary Registration District No. 4173

1. PLACE OF DEATH:
 (a) County Douglas
 (b) City or town Anna
(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 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 Horace M. Curmuth
 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 8
(Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____
If less than one day hr. min.

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

10. Usual occupation Retired County Officer

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) 11-21-46 (b) Wesley Bushman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ Year 1946 Hour _____ Minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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 _____

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

SUPPLEMENTARY

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

36552