

FILED NOV 28 1947

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

37673

State File No. \_\_\_\_\_

Registration District No. 20

Primary Registration District No. 4194

Registrar's No. 99

1. PLACE OF DEATH:

(a) County Gentry  
(b) City or town Albany  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME George William Hunter

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 Widowed  
6. (b) Name of husband or wife Flora Hunter 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased November 7 1857  
(Month) (Day) (Year)

8. AGE: Years 90 Months 0 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Edgar County Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation retired school teacher

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Hunter  
13. Birthplace Edgar Co. Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Maryann Hunter  
15. Birthplace Edgar Co. Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Jones  
(b) Address Walnut, Iowa

17. (a) Burial (b) Date thereof 11/21/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Highland

18. (a) Signature of funeral director [Signature]  
(b) Address \_\_\_\_\_

19. Nov. 22-47 Homer H. Webster  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry 38  
(c) City or town Albany  
(If outside city or town limits write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? No 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19  
year 1947 hour 9 minute P.M.

21. I hereby certify that I attended the deceased from 10-24-1947 to 11-19-1947  
that I last saw him alive on 11-19-1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia (terminal) 10 days  
Due to Mitral stenosis 1/2 century

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy [Signature]  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury U  
23. Signature Frank H. Rose (M. D. or other) M.D.  
Address Albany, Mo. Date signed 11-21-47

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

8761 & WTR  
JAN 20 1949

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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

*Clifford Burke*  
Licensed Embalmer No. *3329*

P. O. Address *Albany 740*

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, above space should be left blank.