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v. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 16 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1707

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

Registration District No. 187

Primary Registration District No. 9040

Registrar's No. 12

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

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution:  
315 Mansur St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX (Specify whether  
years, months or days)

In this community 59 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

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

(d) Street No. 315 Mansur  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country XX

3. (a) PRINT FULL NAME Mary Elizabeth Hunter

3. (b) If veteran, name war XX

3. (c) Social Security No. XX

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife John Hunter

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

7. Birth date of deceased October 28, 1858  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23  
year 1948 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from Jan. 15  
1948, to Jan 23 1948  
that I last saw h. aw alive on Jan. 23 1948  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>89</u>	<u>2</u>	<u>25</u>	<u>X</u> hr. <u>X</u> min.

Immediate cause of death Cerebral Hemorrhage (Paralysis - Rt. Side)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation At home

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business XX

MOTHER FATHER { 12. Name Harvey Cook

13. Birthplace Unknown

14. Maiden name Sarah A. Carnagie

15. Birthplace Unknown

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? \_\_\_\_\_

16. (a) Informant Mrs. Frank Gorman

(b) Address Chillicothe, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-48  
(Month) (Day) (Year)

(c) Place: burial or cremation Jones cemetery

23. Signature Joseph A. Conrad (Specify type of place) (c) Means of injury \_\_\_\_\_

Address Chillicothe, Mo. (Date) Jan 26-48

18. (a) Signature of funeral director Donald J. Gordon

(b) Address Chillicothe, Mo.

19. (a) Jan-27-48 (Date received local registrar) (b) Francis B. Neill (Registrar's signature)

Duration 8 days

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

JUL 17 1958

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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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... *Ronald F. Gordon*

Licensed Embalmer No. *4191*

P. O. Address *Chillicothe, 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.