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1906

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34772

FILED SEP 29 1948  
Registration District No. 349

Primary Registration District No. 4514

Registrar's No. 167

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

1. PLACE OF DEATH:

(a) County SULLIVAN  
(b) City or town GREEN CITY-TOWN.  
(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 LIFE \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County SULLIVAN<sup>103</sup>  
(c) City or town GREEN CITY  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Levina Hunsaker

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W. I  
6. (b) Name of husband or wife JOSEPH HUNSAKER 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 4 25 1860  
(Month) (Day) (Year)

8. AGE: Years 88 Months 4 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation HOUSEWIFE

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

12. Name John McLaughlin  
13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Edith Shepler  
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Ruby Boyd  
(b) Address Green City, Mo.

17. (a) BURIAL (b) Date thereof 9-25-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green City Cem.

18. (a) Signature of funeral director Glenn E. Hunt & Son  
(b) Address Green City Mo.

19. (a) 9-25-48 (b) Louise Cottrell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 23  
year 1948 hour 10: minute 10 P.M.

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

Immediate cause of death Chronic Valvular Disease of Heart  
Due to \_\_\_\_\_

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

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

Major findings: Of operations 977  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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? \_\_\_\_\_ (c) Means of injury U

23. Signature W. Huntington MD (M. D. or other)  
Address Green City Mo. Date signed 9/24/48

RECEIVED

District Health Officer No.                     

District File Number 94916

Date Filed SEP 28 1949

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.....

*Karl R. Kent*

....., Registered Apprentice No. 243

working under my personal supervision.

Signed

*Glenn E. Kent*

Licensed Embalmer No. 1769

P. O. Address

*Green City, 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. 349

Primary Registration District No. 4514

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Green city  
(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) \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether years, months or days) \_\_\_\_\_

3. (a) PRINT FULL NAME Lewina Hussaker

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

4. Sex F 5. Color or race w

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased April 22  
(Month) (Day) (Year)

8. AGE: Years 88 Months 4 Days \_\_\_\_\_ If less than one year \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) No

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) Sept. 26-48 (b) Laura Gallett  
(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 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY 23**

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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S-31772