

S. No. 2  
M-5-43  
5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 28 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Hunter (Leroy)  
State File No. 39817  
Registrar's No. 1096

Registration District No. 128 Primary Registration District No. 5000

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

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution:  
1956 W. Atlantic /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 35 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene 34  
(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1956 W. Atlantic 8  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma Breckenridge  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 18 year 1948 hour 11 minute a. M.  
21. I hereby certify that I attended the deceased from January 2, 1933, to March 4, 1947, that I last saw him alive on March 4, 1947, and that death occurred on the date and hour stated above.

4. Sex Female/ 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Chas. Breckenridge  
6. (c) Age of husband or wife if alive Dec. years  
7. Birth date of deceased Oct. 29 1854  
(Month) (Day) (Year)

Immediate cause of death Senility  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
94 1 20 hr. min.

Other conditions (Include pregnancy, within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Lancaster Ohio /  
(City, town, or county) (State or foreign country)

10. Usual occupation Home

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

12. Name Will Markley

13. Birthplace Ohio /  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Stripe

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

16. (a) Informant Ella Breckenridge  
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 12/20/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

\* (c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director H.H. Lohmeyer  
(b) Address Springfield, Mo.

19. (a) 12-22-48 (b) W.E. Haisley MD  
(Date received local registrar) (Registrar's signature)

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 J. Leroy Hunter (M. D. or other) DE  
Address Land Bank Bldg Date signed 12-20-48

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.....

*Henry Schumyer*, Registered Apprentice No. 292,  
working under my personal supervision.

Signed *Walter E. Hameller*.....

Licensed Embalmer No. 3808.....

P. O. Address Springfield, 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.