

No. 300
10-48

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6305

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1726

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Peoria</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Peoria</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital, 0</u>		d. STREET ADDRESS (If rural, give location) <u>2701 7th St. 2</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>KEITH</u> b. (Middle) <u>GEORGE</u> c. (Last) <u>HUNTER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2 22 1949</u>		
5. SEX <u>Male 0</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married 1</u>	
8. DATE OF BIRTH <u>Dec. 7, 1903</u>		9. AGE (In years last birthday) <u>45</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Canton, Ill. 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Clara Hunter, Peoria, Ill.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clara Hunter, Peoria, Ill.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchogenic Carcinoma & widespread metastases</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>H7C</u>		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>11-3X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2-13 1949, to 2-22 1949, that I last saw the deceased alive on 2-22 1949, and that death occurred at 8:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James F. Nichol, M.D. 0</u>		23b. ADDRESS <u>Barnes Hospital.</u>		23c. DATE SIGNED	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2-23-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		24d. LOCATION (City, town, or county) (State) <u>Peoria, Ill.</u>	
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DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>J. B. Laster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>	
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FEB 23 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed

Robert M. Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo*

Signed _____
Student Embalmer

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.