

FILED MAY 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14909

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 573

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (In this place) 4 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Saxton	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) George	b. (Middle) B	c. (Last) Hunter	4. DATE OF DEATH (Month) (Day) (Year) May 19 49
--	---------------	------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 1, 1865	9. AGE (In years last birthday) 84	10. MONTH (1) 1	11. DAY (18) 18	12. HOUR ( )	13. MIN. ( )
-------------	------------------------	--	--------------------------------	------------------------------------	-----------------	-----------------	--------------	--------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Bloomington Ill.	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	-------------------------------------

13a. FATHER'S NAME Issacs Hunter	13b. MOTHER'S MAIDEN NAME Jane Daley	14. NAME OF HUSBAND OR WIFE May Sophie
-------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. A.A. Karl, Saxton, Mo.	ADDRESS
---	---------------------------------	--	---------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  610X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis, Chronic Hypertension</u>		
	II. OTHER SIGNIFICANT CONDITIONS <u>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> <u>Superiority of Posture</u>  Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 5/10/49 to 5/19/49, 1949, that I last saw the deceased alive on 5/18/49, 1949, and that death occurred at 12:45 m., from the cause and on the date stated above.

23a. SIGNATURE <u>Chas. Chewley M.D.</u>	(Degree or title)	23b. ADDRESS <u>St. Joseph, Mo.</u>	23c. DATE SIGNED <u>5/19/49</u>
---	-------------------	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-21-49	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
---	----------------------	---	--

DATE REC'D BY LOCAL REG May 20, 1949	REGISTRAR'S SIGNATURE <u>B. B. Jenkins</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton-Bauman</u>	ADDRESS <u>St. Joseph, Mo.</u>
---	---	--	-----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

11  
1  
7

*Er. C. Buechling  
Secy. Ill.*

**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.

Student .....  
Student Embalmer

Signed *Eugene Wood* .....

Licensed Embalmer No. *3804*

P. O. Address *319 S. 10th St. Joseph,*

**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.