

FILED FEB 20 1950 THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5230  
Registrar's No. 276

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 17E PRIMARY REG. DIST. NO. 365-2

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) Phelps Greene c. LENGTH OF STAY (In this place) Native		c. CITY (If outside corporate limits, write RURAL and give township) Phelps Greene	
d. FULL NAME OF HOSPITAL OR INSTITUTION Res.		d. STREET ADDRESS (If rural, give location) R.R. 8550	
3. NAME OF DECEASED a. (First) Marion b. (Middle) D c. (Last) Hunt		4. DATE OF DEATH (Month) (Day) (Year) 1-24-1950	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-13-1867
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months 10 Days 11	IF UNDER 11 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lawrence Co.		12. CITIZEN OF WHAT COUNTRY Native	
13a. FATHER'S NAME Woodie Hunt		13b. MOTHER'S MAIDEN NAME Mary Woodson	
14. NAME OF HUSBAND OR WIFE Viola Hunt			
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 Viola Hunt		ADDRESS Phelps Mo	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) fall fractured left DUE TO (c) fractured R. hip II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) none		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
21c. (CITY, TOWN, OR TOWNSHIP) Lawrence (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 1 1949		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? fall in room bathroom			
22. I hereby certify that I attended the deceased from June 1, 1949, to Jan 1950 that I last saw the deceased alive on Jan 18, 1950, and that death occurred at 1-22-50, from the causes and on the date stated above.			
23a. SIGNATURE P. Atchiner		23b. ADDRESS Miller	
23c. DATE SIGNED 1-30-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-24-50	
24c. NAME OF CEMETERY OR CREMATORY Round Grove		24d. LOCATION (City, town, or county) N. W. Miller Mo.	
DATE REC'D BY LOCAL REG. 1-30-50		REGISTRAR'S SIGNATURE W. S. Berry	
158		25. FUNERAL DIRECTOR'S SIGNATURE E. R. Jeman	
ADDRESS Miller Mo.			

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

550  
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APR 8 1950

MAY 1 1950

RECEIVED FEB 18 1950

District Health Office - No. 6,

District File Number 250-228

Date Filed 2-15-50

MAY 22 1950

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 E. R. Lemian

Licensed Embalmer No. 3297

P. O. Address Miller 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.