

FILED SEP 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27763

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 280

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Benton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Warsaw 0080	
c. LENGTH OF STAY (In this place) 5 da		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bothwell Memorial Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Lee	b. (Middle)	c. (Last) Hurt	4. DATE OF DEATH (Month) (Day) (Year) Aug. 26 1950
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 8, 1885	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 6	IF UNDER 1 HR. Days 18	IF UNDER 1 MIN. Hours	Minutes
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor	10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor	11. BIRTHPLACE (State or foreign country) Bolivar, Missouri 0	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John T. Hurt	13b. MOTHER'S MAIDEN NAME Menina Zumalt	14. NAME OF HUSBAND OR WIFE Mrs. Cora Hurt
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO X	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME Mrs. Cora Hurt	ADDRESS Warsaw, Mo
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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 4201
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c)		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Aug 15, 1950, to Aug 26, 1950, that I last saw the deceased alive on 8-26, 1950, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE J. W. Boger M.D.	(Degree or title)	23b. ADDRESS Sedalia Mo	23c. DATE SIGNED 8-28-50
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24a. FUNERAL CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 28, 1950	24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	24d. LOCATION (City, town, or county) (State) Warsaw, Missouri
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DATE REC'D BY LOCAL REG. 8-28-1950	REGISTRAR'S SIGNATURE A. J. Campbell M.D.	FUNERAL DIRECTOR'S SIGNATURE John J. Reser	ADDRESS Warsaw
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 9-5-52
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 9-5-52

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 John F. Reese
Licensed Embalmer No. 4098

P. O. Address Warsaw

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.