

FILED JUL 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22714
Registrar's No. 603

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY Greene b. CITY (If outside corporate limits, write RURAL and give OR TOWN Springfield, Mo.) c. LENGTH OF STAY (In this place) 175 days d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Macoupin c. CITY (If outside corporate limits, write RURAL and give township) Gillespie d. STREET ADDRESS (If rural, give location) 909 3rd Street	
3. NAME OF DECEASED (Type or Print) a. (First) Thomas b. (Middle) _____ c. (Last) Hunter		4. DATE OF DEATH (Month) (Day) (Year) July 11 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH January 12, 1894
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	11. BIRTHPLACE (State or foreign country) Galloway, Alabama
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Retired	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Frank Hunter		13b. MOTHER'S MAIDEN NAME Jane Rutherford	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME VA Hospital Records, Springfield 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-pneumonitis, acute, bilateral ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS (1) Tuberculosis, pulmonary, chronic, far advanced, active. (2) Cor Pulmonale	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	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) 002X
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 January 16, 1951, to July 11, 1951 , and that death occurred at 12:20 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE J. Eisele, MD. (Degree or title)		23b. ADDRESS PROFESSIONAL SERVICES, VA HOSPITAL, SPRINGFIELD, MO	23c. DATE SIGNED 7/11/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 12, 1951	24c. NAME OF CEMETERY OR CREMATORY Unknown	24d. LOCATION (City, town, or county) (State) Gillespie, Illinois
DATE REC'D BY LOCAL REG. 7-12-51	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE Alma Schreyer ADDRESS Springfield, Mo	

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

AUG 20 1914

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 *James W. Wair*

Licensed Embalmer No. *4650*

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.