

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24780

State File No. _____

FILED JUL 29 1952

BIRTH NO. _____		REG. DIST. NO. 150		PRIMARY REG. DIST. NO. 6572		Registrar's No. 133			
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission) a. STATE Mo b. COUNTY Jackson					
c. CITY OR TOWN Independence Rural		c. LENGTH OF STAY (In this place) 2 hrs		c. CITY OR TOWN Oak Grove Rural		0 480			
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson Co. Emergency Hosp				d. STREET ADDRESS (If rural, give location) 4 mi S East					
3. NAME OF DECEASED (Type or Print) Samuel Edward Hunt			a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 17 - 1952			
5. SEX M U		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3		8. DATE OF BIRTH Oct. 17 - 1891			
9. AGE (In years last birthday) 61		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Lafayette Co Mo			
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John Hunt		13b. MOTHER'S MAIDEN NAME Alvira Duke		14. NAME OF HUSBAND OR WIFE -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no. or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ike Monas Bates		ADDRESS City 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) Myocardial Churn				INTERVAL BETWEEN ONSET AND DEATH 5 year	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <input checked="" type="checkbox"/> DUE TO (c) <input checked="" type="checkbox"/>				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <input checked="" type="checkbox"/>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? 4222		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>					
22. I hereby certify that I attended the deceased from July 16, 1952 to July 17, 1952, that I last saw the deceased alive on July 16, 1952 and that death occurred at 7:45 m., from the causes and on the date stated above.									
23a. SIGNATURE (Signature)				23b. ADDRESS (Address)		23c. DATE SIGNED 7-19-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 20 - 1952		24c. NAME OF CEMETERY OR CREMATORY Oak Grove		24d. LOCATION (City, town, or county) (State) Oak Grove Mo			
DATE REC'D BY LOCAL REG. 7-19-52		REGISTRAR'S SIGNATURE Donald C. Eason		E 37879		25. FUNERAL DIRECTOR'S SIGNATURE Webb Funeral Home			
						ADDRESS Oak Grove Mo			

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

0480

JUL 24 REC'D

JUL 31 1958

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

R B Wick

Signed.....

Student Embalmer

Licensed Embalmer No. 235-3

P. O. Address Blue Springs

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.