

FILED MAY 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15059

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 309

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give township) Poplar Bluff		c. CITY (If outside corporate limits, write RURAL and give township) Poplar Bluff	
c. LENGTH OF STAY (in this place) 4 yrs		d. STREET ADDRESS (If rural, give location) 208 South B	
d. FULL NAME OF HOSPITAL OR INSTITUTION 208 South B			

3. NAME OF DECEASED (Type or Print) a. (First) William	b. (Middle)	c. (Last) Hunthausen	4. DATE OF DEATH (Month) (Day) (Year) 5-7-54
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 3, 1872	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Tipton, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
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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) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Records found on person.	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 months 16 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sobar Pneumonia	DUE TO (b) morbid liver	
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>	DUE TO (c) low Metabolism		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	Serility		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 490x	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) (m.)	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 4-30, 1954, to 5-7, 1954, that I last saw the deceased alive on 19, and that death occurred at 7:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE H. H. Burton (Degree or title) MD	23b. ADDRESS Poplar Bluff, Mo	23c. DATE SIGNED 5-13-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-11-54	24c. NAME OF CEMETERY OR CREMATORY Woodlawn	24d. LOCATION (City, town, or county) (State) Poplar Bluff, Mo
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DATE RECD BY LOCAL REG. 5/13/54	REGISTRAR'S SIGNATURE G. W. Mueller	25. FUNERAL DIRECTOR'S SIGNATURE Greer C roy & Fitch	ADDRESS Poplar Bluff
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
MAY 17 1954
BUTLER CO. HEALTH CENTER
FILE No. _____

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 S-7-

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working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Phil A. Luchel

Licensed Embalmer No. 2936

P. O. Address Payler Bluff

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.