

FILED FEB 1 - 1955

STANDARD CERTIFICATE OF DEATH

State File No. **41**

BIRTH NO. _____ REG. DIST. NO. **4** PRIMARY REG. DIST. NO. **4014** Registrar's No. **5**

1. PLACE OF DEATH
a. COUNTY **Atchison**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Missouri** b. COUNTY **Holt**

b. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN **Fairfax**

c. CITY OR TOWN **Mound City**

d. Is Residence within limits of a city or incorporated town?
Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION: **Fairfax Community Hosp.**

e. STREET ADDRESS (If rural, give location) **0440**

3. NAME OF DECEASED
a. (First) **Kenneth** b. (Middle) **Calvin** c. (Last) **Hunt**

4. DATE OF DEATH (Month) (Day) (Year)
Jan. 18, 1955

5. SEX **Male**

6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH **July 19, 1916**

9. AGE (In years last birthday) **38**

IF UNDER 1 YEAR Months Days Hours Min.
38

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman

10b. KIND OF BUSINESS OR INDUSTRY
Alum. Windows

11. BIRTHPLACE (City and State or Foreign Country)
Bigelow, Missouri

12. CITIZEN OF WHAT COUNTRY?
USA

13a. FATHER'S NAME
Calvin B. Hunt

13b. MOTHER'S MAIDEN NAME
Effie F. Guillams

14. NAME OF HUSBAND OR WIFE
Elinor Hunt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No**

16. SOCIAL SECURITY NO. **498-24-5989**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs. Elinor Hunt, Mound 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) **Ruptured mesenteric artery**
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) **Thrombocytopenia**
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH
5 hours
Some Rupture

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. **Thrombocytopenic Purpura**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
296X

20. AUTOPSY?
YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 1, 1903**, to **Jan 18, 1955**, that I last saw the deceased alive on **Jan 18, 1955**, and that death occurred at **5:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
Issac J. Lueane, M.D.

23b. ADDRESS
Oregon, Mo.

23c. DATE SIGNED
1-19-55

24a. BURIAL, CREMATION REMOVAL (Specify)
Burial

24b. DATE
1/21/55

24c. NAME OF CEMETERY OR CREMATORY
Mount Hope Cemetery

24d. LOCATION (City, town, or county) (State)
Mound City, Missouri

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE
Jan 25, 1955, Marvin H. Schaefer

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
James Crawford, Mound City, Mo.

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

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FEB 11 1955

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.....
Signature of Student Embalmer

Signed *James H Crawford*

Licensed Embalmer No. *479*

P. O. Address *Mound City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.