

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22693

FILED AUG 8 - 1956

STATE FILE NUMBER

Registration District No. 4

Primary Registration District No. 4014

Registrar's No. 77

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rock Port Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fairfax Hospital</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>5 mi South Rock Port</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Evelyn</u> Last <u>Hunter</u>			4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31-1891</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>29</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>disabled</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Atchison Co.</u>	
13. FATHER'S NAME <u>John H. Hunter</u>			14. MOTHER'S MAIDEN NAME <u>Juliet Reid</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Herbert Hunter</u> Address <u>Rock Port Mo</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary artery embolus</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Peripartur phlebotrombosis (leg)</u> <u>2 1/2 wks</u>	
	DUE TO (c) <u>Postoperative from cholecystectomy</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral palsy.</u>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>586x</u>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>4:02</u> Month <u>July</u> Day <u>30</u> Year <u>1956</u> a. m. <u>p. m.</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>July 1 1956</u> to <u>July 30</u> and last saw <u>her</u> alive on <u>July 30-56</u> Death occurred at <u>4:02 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>E. A. Little M.D.</u> (Degree or title)		22b. ADDRESS <u>Rock Port Mo</u>		22c. DATE SIGNED <u>8-1-56</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Aug 1-1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hunter Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Rock Port Mo</u>
24. FUNERAL DIRECTOR <u>Bestman Funeral Home - Rock Port Mo</u> ADDRESS	25. DATE RECD. BY LOCAL REG <u>Aug 3, 1956</u>	26. REGISTRAR'S SIGNATURE <u>Thermin H. Schaefer</u>	

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *C. E. Bertram* (by wife)

Licensed Embalmer No...176

P. O. Address *Rock*... *Pa*

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.