

FILED FEB 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4491

STATE FILE NUMBER

 Registration District No. 138 Primary Registration District No. 5527 Registrar's No. 94

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Buck-Tyler Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Tyler Township</u> <u>0430</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 mile East of Elton</u>				Length of stay in lb <u>50 years</u>		d. STREET ADDRESS (If outside, give location) <u>1 mile East of Elton</u>	
3. NAME OF DECEASED (Type or print) First <u>Ardelia</u> Middle Last <u>Hunt</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5-1873</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>Hickory Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>PACIS McCracken</u>				14. MOTHER'S MAIDEN NAME <u>NANCY Adeline SAPP</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>Bulah Hunt - Flemington, 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>Chronic Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>2</u>				
20c. TIME OF INJURY Hour <u>8:00</u> Month <u>Feb</u> Day <u>5</u> Year <u>1957</u> a. m. p. m.							
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>1955</u> to <u>Feb-1957</u> and last saw <u>her</u> alive on <u>2/5/57</u> Death occurred at <u>8:00</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>A. G. Robinson M.D.</u>				22b. ADDRESS <u>Humansville, Mo.</u>		22c. DATE SIGNED <u>2/11/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE: <u>Feb 10-1957</u>	23c. NAME OF CEMETERY OR CREMATORY. <u>Darnell Chapel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Waubesa, Mo</u>		
24. FUNERAL DIRECTOR <u>Sellers, Bethany, Wheeland, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>2-13-1957</u>		26. REGISTRAR'S SIGNATURE <u>May Johnson</u>	

(Licensed Embalmer's Statement on Reverse Side)

300  
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally 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 *Chas. Gilbert Pittaway*

Licensed Embalmer No. *42*

P. O. Address *W. H. H. H.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.