

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006376

STATE FILE NUMBER

FILED FEB 24 1958

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 72

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carrroll</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Low Gap</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>Bryan Rest Home</u>			Length of stay in 1b <u>13 days</u>		d. STREET ADDRESS (If outside, give location) <u>9 mi. SE Braymor</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>ROBERT</u> Last <u>HUNT</u>				4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>'58</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>5/21/1874</u>		9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>Blount Co., Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham L. Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Dunlap</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>K. Hunt, Braymor, 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>Bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>96 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<u>491X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (g) <u>Asthma of unknown duration</u>							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.)					
20c. TIME OF INJURY Hour _____ 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>2/5/58</u> to <u>2/12/58</u> and last saw ^{her} him alive on <u>2/11/58</u> Death occurred at <u>2:05 A. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>William L. Fair, M.D.</u> (Degree or title)				22b. ADDRESS <u>Chillicothe, Mo</u>		22c. DATE SIGNED <u>2/14/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/14/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Braymor, Mo.</u>			
24. FUNERAL DIRECTOR <u>Michael Funeral Home, Braymor, Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2/14/58</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Mehl</u>		

(Licensed Embalmer's Statement on Reverse Side)

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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1-56

Health, Welfare
Public
Service

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 Geneb. Michael.

Licensed Embalmer No. 43

P. O. Address Braymer

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.