

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009086
STATE FILE NUMBER

FILED MAR 24 1958

Registration District No. 46 Primary Registration District No. 5152 Registrar's No. 24

| | | | | | |
|--|-------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Caldwell</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Caldwell</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Polo Hunt.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Polo</u> <u>0139</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>L</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) | | Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hunt</u> Last <u>Hunt</u> | | | 4. DATE OF DEATH <u>Mar. 7-1958</u> Month <u>Mar.</u> Day <u>7-</u> Year <u>1958</u> | | |
| 5. SEX <u>M.</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>Nov. 6-1889</u> | 9. AGE (In years last birthday) <u>68</u> | IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>K.C. Mo. Public Sews</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shut Car.</u> | 11. BIRTHPLACE (City and state or country) <u>Ray Co. Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? |
| 13a. FATHER'S NAME <u>John T. Hunt.</u> | | 13b. MOTHER'S MAIDEN NAME <u>Ida Slack.</u> | | 14. NAME OF HUSBAND OR WIFE <u>Jessie A. Hunt.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>L</u> | | 16. SOCIAL SECURITY NO. <u>510-05-9370</u> | 17. INFORMANT Address <u>Mrs Jessie A. Hunt Polo 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>Cerebral hemorrhage</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ | | | | | |
| DUE TO (c) _____ | | | | | <u>331X</u> |
| 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.) | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 <u>Polo</u> | | COUNTY <u>Caldwell</u> STATE <u>MO.</u> |
| 21. I attended the deceased from <u>Feb 1, 1958</u> to <u>Mar 7, 1958</u> and last saw him alive on <u>5-7-58</u> Death occurred at <u>4:30 pm</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Frank R. Daley, M.D.</u> | | | 22b. ADDRESS <u>Hamilton, Mo.</u> | | 22c. DATE SIGNED <u>3-8-58</u> |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u> | 23b. DATE <u>3-9-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cougill</u> | | 23d. LOCATION (City, town, or county) (State) <u>Cougill Mo Caldwell. Mo</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Olspangh & Cowley Polo Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-14-58</u> | 26. REGISTRAR'S SIGNATURE <u>Gladys Jones.</u> | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, welfare, public service
All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

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 *Erwin L. Howells*

Licensed Embalmer No. *4924*
P. O. Address *Polo, Mo.*

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.