

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031820
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1082

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Plattsburg.</u> 0250 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Methodist Hosp.</u>		Length of stay in lb <u>3 Days.</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle Last <u>Hunter.</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5 1900</u>
9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COMMON</u>	11. BIRTHPLACE (City and state or country) <u>Lower Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Perry Hunter</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Parker.</u>
14. NAME OF HUSBAND OR WIFE		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.
17. INFORMANT <u>Lowell Hunter</u>		Address <u>Plattsburg, 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>Traumatic Shock, intraabdominal</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Ruptured transverse Colon</u> DUE TO (c) <u>Direct blow from heavy steel object</u>			INTERVAL BETWEEN ONSET AND DEATH <u>29 hrs</u> <u>29 hrs</u> <u>29 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>9105</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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>working on construction when heavy steel girder fell across abdomen and knocked down</u>		
20c. TIME OF INJURY Hour Month, Day, Year <u>1039 a.m. 10-6-58</u>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>on County Road</u>	20f. CITY, TOWN, OR LOCATION <u>Plattsburg</u>
20g. COUNTY <u>Clinton</u>		20h. STATE <u>Mo.</u>	
21. I attended the deceased from <u>10-6-58</u> to <u>10-7-58</u> and last saw him <u>at home</u> on <u>10-7-58</u> Death occurred at <u>400 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>John P. Mahony M.D.</u>	
22b. ADDRESS <u>Plattsburg, Mo.</u>		22c. DATE SIGNED <u>10-8-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Oct. 25 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Plattsburg</u>	23d. LOCATION (City, town, or country) (State) <u>Plattsburg Missouri</u>
24. FUNERAL DIRECTOR <u>LYON FUNERAL HOME</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 10, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Phillip E. Bod*

Licensed Embalmer No. *1993*

P. O. Address *Stamberg*

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.