

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005158

STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 152A

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u> ^{c396}
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>717 E. Belmont</u>		Length of stay in lb <u>50 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>717 E. Belmont</u>
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Alice</u> Last <u>Hunt</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1959</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"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 16, 1860</u>
9. AGE (In years last birthday) <u>98</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Greene County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Robert Wilson</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah McAdams</u>		14. NAME OF HUSBAND OR WIFE <u>Taylor Hunt, (Dec.)</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>None</u>	17. INFORMANT (Name) <u>Grace Smith</u> Address <u>Mt. Vernon, Missouri</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>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic cardiovascular disease.</u>			
DUE TO (c) <u>Age</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Enterocolitis</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 <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1938</u> to <u>death</u> and last saw her ^{her} look alive on <u>February 6, 1959</u>		Death occurred at <u>9:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Edward G. Hall M.D.</u>		22b. ADDRESS <u>1211 S. Glenstone, Springfield</u>	22c. DATE SIGNED <u>2/14/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-13-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>Mo.</u> (State) <u>Springfield, Missouri</u>
24. FUNERAL DIRECTOR <u>Rex Rainey</u> ADDRESS <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-16-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

All diseases in Part I must use only standard nomenclature in item 18. No symptoms will be listed. No diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 24 1958

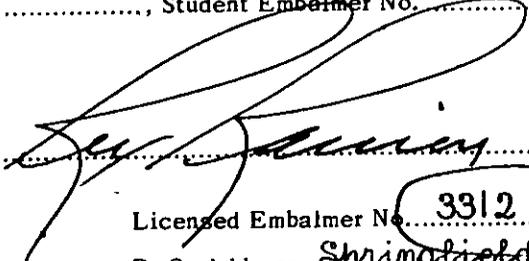
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STATEMENT BY LICENSED EMBALMER

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  _____
Licensed Embalmer No. 3312
P. O. Address Springfield, 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.