URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

-60-037796
STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 5290 Registrar's No. 109

NDED

1. PLACE OF DEATH
a. COUNTY: CLAY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KEARNEY TWP — Length of stay in 1b: LIFETIME
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2 mi. N. KEARNEY — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: CLAY
c. CITY OR TOWN: HOLT — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 4 mi. S. HOLT — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First BESSIE Middle LEE Last HUNTER
4. DATE OF DEATH: Month OCT. Day 20 Year 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 1-14-1882
9. AGE (last birthday): 78
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (City and state or country): BATES Co. Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: JONATHAN SAIGHMAN
13b. MOTHER'S MAIDEN NAME: LUCY WHITTAKER
14. NAME OF HUSBAND OR WIFE: LEONARD W. HUNTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 488-46-8122
17. INFORMANT: MRS. TRIGG LONG Address: RT. #1, HOLT MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	12 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Metastatic Carcinoma of Cerebrum	2 weeks
DUE TO (c)	Carcinoma of Bladder	2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerosis and Atherosclerosis generalized 5 yrs

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 May 1958, to Oct. 20, 1960 I last saw her alive on Oct. 20, 1960
Death occurred at 1:25 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John P. Mabrey (Degree or title) M.D.
22b. ADDRESS: Plattsburg, Mo
22c. DATE SIGNED: 10-20-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10-23-60
23c. NAME OF CEMETERY OR CREMATORY: ANTIOCH
23d. LOCATION (City, town, or county) (State): HOLT Mo.
24. FUNERAL DIRECTOR: FRY FUNERAL HOME ADDRESS: KEARNEY, Mo.
25. DATE RECD. BY LOCAL REG.: 10-25-60
26. REGISTRAR'S SIGNATURE: Mabel Graham

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or ~~by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Linden Jam

Licensed Embalmer No. 458

P. O. Address Excelsior Springs

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