MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-030820
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8035

FILED SEP 6 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): BARNES HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: Saint Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4831a Kossuth
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First HARRY Middle NMN Last HUNTER
4. DATE OF DEATH: Month August Day 27 Year 1961
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5/25/08
9. AGE (last birthday): 53
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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Storage Mound City Cold
11. BIRTHPLACE (City and state or country): Calvary, Texas
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Wilson Hunter
13b. MOTHER'S MAIDEN NAME: Addie Turner
14. NAME OF HUSBAND OR WIFE: Alma Hunter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): --
17. INFORMANT: Alma Hunter, Address: 4831a Kossuth

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interventricular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: ~~6 mos.~~
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Meningioma of the right lateral ventricle of the brain
DUE TO (c): 223x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
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 7/8/61 to 8/27/61 and last saw ~~him~~ her alive on 8/27/61
Death occurred at 7:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: C. O. Vermillion, M.D. (Degree or title): C. O. Vermillion, M.D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 8/28/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9/1/61
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.
24. FUNERAL DIRECTOR: Charles J. Gates, ADDRESS: 4107 Finney
25. DATE RECD. BY LOCAL REG.: AUG 29 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

RATE AMENDED — INSTEAD OF — DOCUMENT — SHOULD READ — BY AFFIDAVIT OF — ITEM NO.

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_____ Signed Guyton Swan
Signature of Student Embalmer

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.