

## OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041453

AMENDED

 Registration District No. 157 Primary Registration District No. 5584 Registrar's No. 244 STATE FILE NUMBER

FILED DEC 13 1961

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>McDONALD SARGOXIE R.T.D.</u>		Length of stay in 1b		c. CITY OR TOWN <u>Sargoxie</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.F.D. #</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Nell</u> Middle <u>Hunt</u> Last <u>Hunt</u>				4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1961</u>					
5. SEX <u>Female</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>12-3-1881</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>2</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lawrence Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Ab Robertson</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Hudspeth</u>			14. NAME OF HUSBAND OR WIFE <u>O.B. Hunt</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 <u>O.B. Hunt</u>		Address <u>Sargoxie Mo. R. 1, B.</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>Aspiration due to</u> <u>aspiration. Accorrd Rectu.</u> DUE TO (b) <u>Fractured hip - bed. sore</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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>12-1-61</u> to <u>12-5-61</u> and last saw her/him alive on <u>12-1-61</u> Death occurred at <u>4:45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W. S. Bourque M.D.</u> (Degree or title)				22b. ADDRESS <u>Miller Mo.</u>				22c. DATE SIGNED <u>12-5-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-7-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Round Grove</u>		23d. LOCATION (City, town, or county) <u>N.W. of Miller Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Morris Seiman</u> ADDRESS <u>Miller Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-6-61</u>		26. REGISTRAR'S SIGNATURE <u>Ely Clinton</u>				

DOCUMENT

MEDICAL CERTIFICATION

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 me

~~or by~~

\_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*L. R. Seiman*

Licensed Embalmer No.

3297

P. O. Address

*Miller M.*

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.