

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-47935  
14-62 STATE FILE NUMBER

AMENDED

Registration District No. 195 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**FILED MAR 21 1962**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>McDONALD</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NOEL</u>		Length of stay in lb <u>10 WEEKS</u>	c. CITY OR TOWN <u>SEYMOUR</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>JOHN</u> Middle <u>E.</u> Last <u>HUNT</u>			<b>4. DATE OF DEATH</b> Month <u>10</u> - Day <u>24</u> - Year <u>61</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-3-1878</u>	<b>9. AGE (last birthday)</b> <u>83</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <u>WEBSTER Co. MO.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>

<b>13a. FATHER'S NAME</b> <u>JOE HUNT</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>MARY MANN</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>EUNICE RHOTEN NOEL, MO.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>EUNICE RHOTEN NOEL, MO.</u>

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. _____ Month, Day, Year _____					

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
<b>21. I attended the deceased from</b> <u>9-24/61</u> to <u>10/24/61</u> and last saw <sup>him</sup> alive on <u>10/24/61</u> Death occurred at <u>5:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

<b>22a. SIGNATURE</b> (Degree or title) <u>H.D. Jourdain M.D.</u>		<b>22b. ADDRESS</b> <u>MO. MO.</u>		<b>22c. DATE SIGNED</b> <u>3/10/62</u>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE</b> <u>10-27-61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SEYMOUR MASONIC</u>	<b>23d. LOCATION</b> (City, town, or county) <u>WEBSTER CO.</u> (State) <u>MO.</u>	

<b>24. FUNERAL DIRECTOR</b> <u>Robert Bergman Seymour, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>March 15, 1962</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Mary G. Brudley</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

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 Max J Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield 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.