

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003State File No. **37085**
9358
Registrar's No.Registration District No. **791**

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Homer Phillips Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **16 days**
 (Specify whether _____)
 In this community **23 years**
 years, months or days)

8. (a) PRINT FULL NAME **Stella Hunter**8. (b) If veteran, ----- 8. (c) Social Security
name war ----- No. -----

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married,
divorced **Widow**
 6. (b) Name of husband or wife **Mason Hunter** 6. (c) Age of husband or wife if
alive _____ years
 7. Birth date of deceased **9 26 1881**
 (Month) (Day) (Year)

8. AGE: Years **55** Months **9** Days **16** If less than one day
hr. _____ min. _____9. Birthplace **Okalona Mississippi**
(City, town, or county) (State or foreign country)10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
 12. Name **Sam Clark**
 13. Birthplace **Unavailable Mississippi**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Emma Lagrone**
 15. Birthplace **Unk. Virginia**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Leola Chapman**(b) Address **3924 Fairfax Ave.**17. (a) **Burial** (b) Date thereof **11-15-40**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Washington Park Cem.**18. (a) Signature of funeral director **Chas. G. Galt**(b) Address **4107 Finney Ave.**19. **NOV 14 1940** (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St Louis** //
 (If outside city or town limits, write "RURAL")
 (d) Street No. **3924 Fairfax**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **12**
year **1940** hour **8:45** minute _____ A. M.21. I hereby certify that I attended the deceased from
October 28, 19**40**, to **November 12**, 19**40**;
that I last saw her alive on **November 12**, 19**40**;
and that death occurred on the date and hour stated above.Immediate cause of death **Hypertensive Heart Disease c
Decompensation** Duration **10-12mos**

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged statisti-
cally

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature **Edith L. Whitaker** (M. D. or other) _____
Address **2601 N Whittier** Date signed _____

STATEMENT BY LICENSED EMBALMER

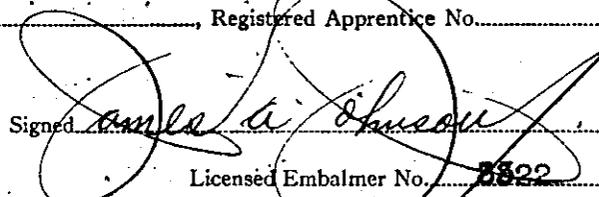
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

....., Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No. 5822

P. O. Address 4107 Finney Ave.

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 this body is not embalmed, above space should be left blank.