

No. 2  
- 9-43  
5-17-39  
X37823

**FILED JUL 9 1945**

Registration District No. 23 Primary Registration District No. 3010 Registrar's No. 174

**1. PLACE OF DEATH:**

(a) County Cape Girardeau

(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Francis Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether  
In this community 5 days years, months or days)

**3. (a) PRINT FULL NAME** Emily Augusta Huntsinger

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Frank Huntsinger

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 16th 1859  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>86</u>	<u>2</u>	<u>15</u>	hr. _____ min.

9. Birthplace Neelys Landing Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Postmistress

11. Industry or business of Neelys Landing

12. Name Edmund Hines

13. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

14. Maiden name Emily Russell

15. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Hines Russell

(b) Address Neelys Landing, Missouri

17. (a) Burial (b) Date thereof 6-03-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Apple Creek Cemetery

18. (a) Signature of funeral director L. L. Haman

(b) Address Cape Girardeau, Missouri

19. (a) 6-12-45 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Cape Girardeau

(c) City or town Neelys Landing !!  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 1st  
year 1945 hour 1 minute 20 A.M.

21. I hereby certify that I attended the deceased from Oct  
1944 to June 1, 1945  
that I last saw her alive on May 31, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 hr

Due to Hypertension 5 yr

Due to Arterio Sclerosis 10 yr

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy HW

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

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 T. E. Ruff (M. D. or other) MD

Address Jackson MO Date signed 6/2/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1014

RECEIVED

District Health Officer No. 4

District File Number 745-811

Date Filed 7-6-45

SEP 18 1945

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.....

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

working under my personal supervision.

Signed Howard S. Stinson

Licensed Embalmer No. 4122

P. O. Address Cape Girardeau, Missouri

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

*Jay June*  
State File No. *July*  
Registrar's No. *178*

Registration District No. *53*

Primary Registration District No. *2070*

Registrar's No. *178*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME *Emily A. Huntsinger*

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex *F* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased *mar 16* (Month) (Day) (Year)

8. AGE: Years *86* Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country) *Mo*

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) *6-12-45* (Date received local registrar) (b) *(F. W. Phelps)* (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* Day *14* year *1945* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

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 statistically.

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..... (M. D. or other)

Address..... Date signed.....

SEP 18 1945

S-20042