MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County St. Louis

Township or Village Meramec

Registration District No. 785 File No. 20539

Primary Registration District No. 6082 Registered No. 67

City (NO. , St., Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Curtis Leeco Whitworth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept 7 (Month) (Day), 1899 (Year)

7 AGE: 19 yrs. 9 mos. 26 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): Government work

9 BIRTHPLACE (City or town, State or foreign country): St. Louis City

PARENTS

10 NAME OF FATHER: Garland L. Whitworth

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Jefferson Co. Mo.

12 MAIDEN NAME OF MOTHER: Anna M. Porter

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): St. Charles Co. Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Garland L. Whitworth
(Address) Glencoe Mo.

15 Filed 6/6, 1919. Dunnavant C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 3 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 28, 1919, to June 3, 1919, that I last saw him alive on June 3, 1919, and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:
Obstruction of Bowel
Work 1929
109
(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): acute attack
(Duration) yrs. mos. ds.

(Signed) Robert Terry Jr. M. D.
6/4, 1919 (Address) Chesterfield

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Antioch Cemetery

DATE OF BURIAL: June 5, 1919

20 UNDERTAKER: Wm. Schrader

ADDRESS: Bellwin Mo

1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEAL
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CERTIFICATE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurre hospital or insti give its NAME i of street and nu

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191.

17 I HEREBY CERTIFY, that I attended deceased ....., 191....., to ....., 19

that I last saw h..... alive on ....., 19

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Caus (1) Means of Injury; and (2) whether Accidental, Suicidal or Hor

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 1

20 UNDERTAKER

ADDRESS