WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Lincoln

Township Hawk Point, or Village ✓ or City ✓ (NO. ____ St.: ____ Ward)

Registration District No. 488, File No. 8 7661

Primary Registration District No. 6365, Registered No. ____

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

FULL NAME Grover C Witt

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Oct (Month) 4 (Day), 1892 (Year)

AGE: 27 yrs. 4 mos. 19 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Farmer

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

BIRTHPLACE (City or town, State or foreign country): Lincoln Co. Mo.

PARENTS

NAME OF FATHER: Wm. H. Witt

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

MAIDEN NAME OF MOTHER: Virginia F. Douglass

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. H. Witt.

(ADDRESS) Troy Mo. R. #3.

Filed 2-24, 1920. W. F. Guinn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

DATE OF DEATH: February (Month) 23 (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 13, 1920, to Feb 23, 1920, that I last saw him alive on Feb 22, 1920, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

11A 10

108 (Duration) ___ yrs. ___ mos. 10 ds.

Contributory (SECONDARY) Influenza

(Duration) ___ yrs. ___ mos. 15 ds.

(Signed) L Pendleton M. D.

8 Feb 23, 1920 (Address) Troy Mo.

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

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 ____

PLACE OF BURIAL OR REMOVAL: Nichols Cemetry

DATE OF BURIAL: 2-24-1920

UNDERTAKER: Ordelheide & Co

ADDRESS: Hawk Point, Mo.

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.: _____ Ward)

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

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

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

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

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 _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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