

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

Do not use this space.

20324

1. PLACE OF DEATH

County Saline
Township Marshall
City Marshall

Registration District No. 796
Primary Registration District No. 6039

File No. _____
Registered No. 77
St. _____ Ward _____

2. FULL NAME

Virginia DeWitt

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 1 mos. 24 ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28, 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
15 — 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) McClinton
(STATE OR COUNTRY) Oklahoma

10. NAME OF FATHER Bruce T. DeWitt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Johnson County
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Kate Eichenberger
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ozark
(STATE OR COUNTRY) Arkansas

14. INFORMANT Record of Mo. State School
(Address) Marshall, Missouri

15. FILED 6/6, 1927 Dr. Manning
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 3, 1927

17. I HEREBY CERTIFY, That I attended deceased from October 20, 1925, to June 3, 1927, that I last saw him alive on June 3, 1927, and that death occurred, on the date stated above, at 8:03 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute B. bronchopneumonia — primary
1078 1000 (duration) _____ yrs. _____ mos. 3 ds.
CONTRIBUTORY Evolution of Idiocy
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) R. P. Crank, M. D.

June 4, 1927 (Address) Mo. State School Marshall Mo.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Billings, Mo. DATE OF BURIAL June 8 1927
20. UNDERTAKER R. W. Campbell ADDRESS Marshall Mo.

CAUSE OF DEATH - Every item of information should be carefully supplied.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Saline
Township Marshall
City Marshall (No.)

Registration District No. 796
Primary Registration District No. 6039

File No.
Registered No. 77
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX D 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28, 1912

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.
15 — 6

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15.

FILED 8/18, 1927

D. H. Manning
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 3, 1927

17. I HEREBY CERTIFY That I attended deceased from to
that I last saw h. alive on 19....., and that
death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
..... 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

AGE at
may be properly classified.

AGE at
may be properly classified.

REG. 95 41

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3