

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

Do not use this space.

16385

1. PLACE OF BIRTH

County Calloway Registration District No. 104 File No. _____
 Township _____ Primary Registration District No. 9009 Registered No. 113
 City Fulton (No. _____) St. _____ Ward _____

2. FULL NAME

Theodore Gates Kitzell
 (a) Residence No. Hospital #1 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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) not given

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
38

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) not given
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not given
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not given
 (STATE OR COUNTRY)

14. INFORMANT Hospital Records
 (Address) Fulton Mo

15. May 30 1928 R. P. Crewley
 FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24 1928

17. I HEREBY CERTIFY That I attended deceased from Jan 1 1928, to May 29 1928 (that I last saw him alive on May 8 1928 and that death occurred, on the date stated above, at _____ m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic passive dysentery
suppurative

CONTRIBUTORY (SECONDARY) 131 / 1290

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) R. P. Crewley, M. D.
5-25-28 (Address) Fulton 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 DATE OF BURIAL

Hospital #1 cemetery 5/30 1928

20. UNDERTAKER Herndon Taylor ADDRESS Fulton Mo

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.

1928

