

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

Do not use this space.

9717

1. PLACE OF DEATH

County Buchanan Registration District No. 85
Township _____ Primary Registration District No. 1001
City St. Joseph (No. St. Joseph Hospital)

File No. _____
Registered No. 424
St. _____ Ward)

2. FULL NAME Fred Roy Chitwood

(a) Residence. No. 1429 North 10th Street St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 13 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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 Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 16, 1916

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>13</u>	<u>2</u>	<u>14</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) St. Joseph
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER N.O. Chitwood

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

12. MAIDEN NAME OF MOTHER Myrtle Sellers

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

14. INFORMANT Hrs Ollie Sellers
(Address) 1429 North 10th Street

15. FILED 1 1929
John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 30 19 29

17. I HEREBY CERTIFY, That I attended deceased from 3-15, 1929, to 3-30, 1929, and that I last saw him alive on 3-30, 1929, and that death occurred, on the date stated above, at 11-45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1918
107A
Trachea Pneumonia
(duration) _____ yrs. _____ mos. 8 ds.
CONTRIBUTORY oper for Appendicitis
(SECONDARY) (duration) _____ yrs. _____ mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____
DATE OF OPERATION PRECISE DEATH 3/18/29
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) C. H. [Signature], M. D.

April 1 19 29 (Address) 101 1/2 W Mo Ave

*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 Mt. Auburn Cemetery DATE OF BURIAL April 1 1929

20. UNDERTAKER H.O. Sidenfader ADDRESS 1802 Union St.

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.

11
23
66
9
201
1
2
1

1929

