

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

Do not use this space.

30426<sup>r</sup>

29 1930  
L. Lincoln  
1. PLACE OF DEATH  
County Lincoln Registration District No. ....  
Township North Primary Registration District No. 494  
City (No. 1638) St. .... Ward)  
2. FULL NAME Dr. Walter L. Northcutt  
(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. 56 mos. 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) widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF widowed  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
82 11 21  
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work M.D.  
(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) Callaway Co. Mo.  
10. NAME OF FATHER Leahel Northcutt  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky  
12. MAIDEN NAME OF MOTHER Mary Pemberton  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

14. INFORMANT (Address) Mrs. Clay Pennington  
Olney, Mo.  
15. FILED 9/13 30 REGISTRAR W. H. Reader

**1 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 12 1930  
17. I HEREBY CERTIFY, That I attended deceased from Sept 4<sup>th</sup>, 1930; to Sept 12, 1930, that I last saw alive on Sept 12, 1930, and that death occurred, on the date stated above, at 10:30 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute Enterocolitis  
12 (duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) 114B (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) Dr. W. L. Drunnet, M. D.  
. 19 (Address) Dixton 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 Olney DATE OF BURIAL 9/14 1930  
20. UNDERTAKER Vernon Shuley ADDRESS Olney Mo.

N. B.—Every item of information shown 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.

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**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 Lincoln Registration District No. 494 File No. ....  
 Township Nunevah Primary Registration District No. 5-6-3-8 Registered No. ....  
 City..... (No.)..... St. .... Ward.....

**2. FULL NAME**

Walter L. Northcutt

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11/21/1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
82 11 21

**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 9/13/30 W. Riddle REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 12 1930

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... 19..... 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:

..... (duration) yrs. mos. ds.  
 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  
 19

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-30426