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

Do not use this space.

1. PLACE OF ~~DEATH~~
County Stoddard — Registration District No. 837 — File No. 27279
Township Castor — Primary Registration District No. 6099 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME J. W. Hutchison
(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) Married

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
72	1	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(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) Tenn

PARENTS
10. NAME OF FATHER J. M. Hutchison
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Alabama
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT J. P. Hutchison
(Address) Bloomfield Mo.

15. Aug 10, 1931 Edw. Ford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-19 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec. 14th, 1930 to July 19, 1931 that I last saw ~~[illegible]~~ alive on July 17, 1931, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess of left Lung
109A
114B
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Pneumonia Ach. 1936
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) S. S. Davis, M. D
, 19 (Address) Dexter 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 Sick Creek Cemetery — DATE OF BURIAL 7-20 1931

20. UNDERTAKER J. A. Chiles & Co. — ADDRESS Bloomfield

CAUSE of [illegible] information should be [illegible] supplied. AGE should be stated EXACTLY. PHYSICIANS should state [illegible] properly classified. Exact statement of OCCUPATION is very important.

AUG 29 1931

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

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: Stoddard — Registration District No. 837
Township: Castor — Primary Registration District No. 6099
City ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME: J. W. Hutchison

(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): M

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
72	1	4	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

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

FATHER
13. NAME .....
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

MOTHER
15. MAIDEN NAME: Mary L. Rose
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

17. INFORMANT (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ....., 19....

19. UNDERTAKER (ADDRESS) .....

20. FILED Aug 10, 1931 Ella Fox
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 19, 1931

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Other contributory causes of importance:	

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) ....., M. D.
(Address) .....

SUPPLEMENTARY

S-27979