

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

JAN 11 1935

42735

1. PLACE OF DEATH

County Henry

Registration District No. 352

File No.

Township Montrose

Primary Registration District No. 4209

Registered No. 19

City Montrose (No.

St.

Ward)

2. FULL NAME

(a) Residence. No. Montrose St.

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 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) Married

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

Ada Littlejohn

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

June 30 1868

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

66
10
17

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).

self

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Lynn Co Kans

10. NAME OF FATHER

Henry Littlejohn

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Indiana

12. MAIDEN NAME OF MOTHER

Melinda Cash

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Indiana

14. INFORMANT

(Address)

Ada Littlejohn
Montrose Mo

15. FILED

12-22-34
J M Miller

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-27-34

17. I HEREBY CERTIFY, That I attended deceased from Nov 7th 1934 to Dec 27 1934 that I last saw him alive on Dec 26 1934 and that death occurred, on the date stated above, at 5:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Stomach

CONTRIBUTORY (SECONDARY)

(duration) 1 yrs. 6 mos. da.

(duration) yrs. mos. da.

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) D J M Miller M. D.

12-27-34 (Address) Montrose 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. Woodrich Kansas

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Montrose Mo
12-28-34

20. UNDERTAKER

ADDRESS

Fred Wilkinson Clinton

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

1. PLACE OF DEATH

County..... File No.....
 Township..... Registered No.....
 City..... (No.)..... St. Ward)

2. FULL NAME

(a) Residence, No. St. Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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.

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

PARENTS

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..... 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

19

17. I HEREBY CERTIFY, That I attended deceased from..... 19..... to..... 19.....

that I last saw him 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..... (duration) yrs. mos. ds.

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

M. D.

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