

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

Do not use this space.

JUN 12 1937

18598

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No. *2*)

*Hospital*

791

1003

File No.....

Registered No.....

5174

St.....

Ward.....

2. FULL NAME

*Will Whitfield*

(a) Residence, No. *1104-N-19* St., *21* Ward.

(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

*Male*

4. COLOR OR RACE

*Cal*

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

*Married*

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

*Fuller Whitfield*

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

*Dec 22 - 1892*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*31*

*45*

*4*

*22*

OCCUPATION

8. Trade, profession, or particular kind of work done, as planer, 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.....

*Gabar*

*Gabar*

12. BIRTHPLACE (CITY OR TOWN)

*Maybrough Miss*

13. NAME

*Jim Whitfield*

14. BIRTHPLACE (CITY OR TOWN)

*Not known Miss*

15. MAIDEN NAME

*Malinda Porter*

16. BIRTHPLACE (CITY OR TOWN)

*Not known Miss*

17. INFORMANT

*Fuller Whitfield*

(ADDRESS)

*1104 N 19 St*

18. BURIAL, CREMATION, OR REMOVAL

PLACE

*Washington Park*

DATE *5-24*

19. UNDERTAKER

*Richardson*

(ADDRESS)

*2600 N 9th St*

20. FILED

MAY 24 1937

Registrar.

NO ATTENDING PHYSICIAN MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-19* 19*37*

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to ....., 19.....

I last saw him..... alive on....., 19..... Death is said

to have occurred on the date stated above, at *12:45 AM*

The principal cause of death and related causes of importance were as follows:

*Apoplexy*

Other contributory causes of importance:

*Arteriosclerosis*

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? *No*

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 *4*

Nature of injury *4*

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify.....

(Signed) *Alfred Perry*

(Address) *Deputy Coroner*

2439

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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.

