

REC'D MAY 18 1938

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

14613

Do not use this space.

1. PLACE OF DEATH *Greene*

(a) County *Greene* Registration District No. *316*

(b) Township *Springfield* Primary Registration District No. *2001*

(c) City *Springfield* (d) Street No. *St. Johns Hospital* Registered No. *302*

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *RALPH WITT* *300*

(a) Residence, No. *R #1* St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

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 *NORA WITT*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 5-1913*

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

24 4 0

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Laborer*

9. Industry or business in which work was done, as saw mill, bank, etc. *-*

10. Date deceased last worked at this occupation (month and year) *-*

11. Total time (years) spent in this occupation *7*

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

FATHER

13. NAME *Thomas J. Witt*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

MOTHER

15. MAIDEN NAME *Mary Ellen Caddy*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT (ADDRESS) *Nora Witt, Springfield, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Green Lawn, Springfield, Mo.* DATE *April 7, 1938*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. H. Hignat, Springfield, Mo.*

20. FILED *April 16, 1938* *Chas. George, Local Registrar, 296*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 5, 1938*

22. I HEREBY CERTIFY, That I attended deceased from *Feb. 20, 1938* to *Apr. 5, 1938*

I last saw him alive on *Feb. 4, 1938*. Death is said to have occurred on the date stated above, at *7:22 a.m.*

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

Colitis Ulcerativa

Date of onset *Feb. 28*

Other contributory causes of importance: *Peritonitis (resulting from ulcerative colitis perforating)* *Apr. 3, 1938*

Name of operation *none* Date of *-*

What test confirmed diagnosis? *-* Was there an autopsy? *yes*

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? *no*

If so, specify *Francis B. Camp, M. D.* (Signed) *Springfield* (Address)

Licensed Embalmer's Statement on Reverse Side)

CRUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

J.B. Klingner # *3358* by *Mrs. Max Rhoads*
Registered Apprentice No. *117* working under my personal supervision.

Signed

J.B. Klingner

Licensed Embalmer No. *3358*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.