

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

22113
Do not use this space.

DEED JUL 11 1939
1. PLACE OF DEATH
(a) County GREENE Registration District No. 318
(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 468
(c) City SPRINGFIELD (d) Street No. 2029 N. Weller. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Fred De Witt
(a) Residence, No. 2029 N. Weller 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 Elsie DeWitt
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 4 1901
7. AGE YEARS 38 MONTHS 5 DAYS 3 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. + Laborer
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) Stone County (STATE OR COUNTRY) Mo.
13. NAME W. G. De Witt
14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)
15. MAIDEN NAME Mollie Unknown
16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)
17. INFORMANT Elsie De Witt (ADDRESS) 2029 N. Weller
18. BURIAL, CREMATION, OR REMOVAL PLACE Dodson Cem DATE June 9, 1939
19. FUNERAL DIRECTOR (NAME) Alvin Johnson (ADDRESS) Springfield Mo.
20. FILED 6-9 19 39 Chas. A. George Mo. Regist.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 7, 1939
22. I HEREBY CERTIFY, That I attended deceased from 6-7-1939 to 6-7-1939. Death is said to have occurred on the date stated above, at 12:15 A. The principal cause of death and related causes of importance were as follows:
Pulmonary Tuberculosis
died at home
Other contributory causes of importance: 22
Name of operation clinical Date of 22
What test confirmed diagnosis? clinical Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury no
Where did injury occur? no (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury no
Nature of injury no
24. Was disease or injury in any way related to occupation of deceased?
If so, specify no
(Signed) J. P. Ferguson M. D. (Address) 604 E. 2nd St

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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

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