

FILED FEB 12 1940

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

2808  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Johnson Registration District No. 426  
(b) Township #Chilhowee Primary Registration District No. 4252  
(c) City Chilhowee (d) Street No. \_\_\_\_\_ 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

Kenzie K. Gittings 352

(a) Residence, No. \_\_\_\_\_ 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 Jessie Gittings

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 8th 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 7 3

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired mail carrier  
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) 1934 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chilhowee Mo13. NAME Alonzo Gittings14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill15. MAIDEN NAME Sarah Hampson16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known17. INFORMANT (ADDRESS) Mrs. Jessie Gittings Chilhowee, Mo18. BURIAL: CREMATION OR REMOVAL PLACE Pisgah Cem DATE 1-16-194019. FUNERAL DIRECTOR (NAME) (ADDRESS) O. L. Cook Chilhowee Mo20. FILED 1-12 19 40 O. L. Cook Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jany 9-194022. I HEREBY CERTIFY, That I attended deceased from JAN 9TH 1940, to JAN 9 1940I last saw him alive on JAN 9TH 1940. Death is said to have occurred on the date stated above, at 10:30 a.m.

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

CORONARY OCCLUSION

Date of onset

1/9-40

Other contributory causes of importance:

ARTERIO SCLEROSISunknown yearsName 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 \_\_\_\_\_

Nature of injury \_\_\_\_\_

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

If so, specify \_\_\_\_\_

(Signed) G. W. Kendall, M. D.(Address) Chilhowee Mo

RECEIVED  
District Health Officer No. 8  
File Number  
07/15/40

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~~

*O. R. Leach*

~~Registered Apprentice No.~~

~~working under my personal supervision.~~

Signed *O. R. Leach*

Licensed Embalmer No. *2708*

P. O. Address *Chilhowee*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2808  
Registrar's No. 2

Registration District No. 426

Primary Registration District No. 4252

1. PLACE OF DEATH:

(a) County Johnson  
(b) City or town Chilhowee  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson  
(c) City or town Chilhowee  
(If outside city or town limit, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Kinzie Kern Gittings 352

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Jessie Gittings 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased June 8 1871  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>7</u>	<u>1</u>	_____ min.

9. Birthplace Rose Hill Township Johnson Co  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Mail Carrier

11. Industry or business \_\_\_\_\_

12. Name Alonzo Gittings

13. Birthplace state of Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Ann Hinkson

15. Birthplace Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant Jessie M. Gittings ✓

(b) Address Chilhowee Mo

17. (a) Burial (b) Date thereof 1-16-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pisgah Cem

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address Chilhowee Mo

19. (a) 1-12-40 (b) O. L. Cook  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9th  
year 1940 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 9th  
1940 to Jan 9th, 1940.  
I last saw him alive on Jan 9th, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion 3.0 min

Due to Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: L. M. Kendall M.D.

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

**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.....

*O. P. Cook*

Licensed Embalmer No. 2708

P. O. Address Chilhowee, Mo

**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.)**

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