

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

6111
Do not use this space.

1. PLACE OF DEATH

(a) County Caldwell Registration District No. 99

(b) Township Rockford Primary Registration District No. 3-147 Registered No. _____

(c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(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 Albert Richard Hutchings

(a) Residence, No. Caldwell Co. Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 14 1901

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

41 2 11

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

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) Feb 15 1940

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rockford Twp, Caldwell Co Mo

FATHER

13. NAME Richard Hutchings

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Caldwell Co Mo

MOTHER

15. MAIDEN NAME Maggie Sharp

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pay Co Mo

17. INFORMANT (NAME) (ADDRESS) Bradella May Hutchings Elmira Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Prairie Ridge Feb 20 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Aspenhaw Cowley Palo Mo.

20. FILED Mar 1 1940 Mrs Wylie Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 25th 1940

22. I HEREBY CERTIFY That I attended deceased from Feb. 19 1940, to Feb. 25th 1940. I last saw him alive on Feb. 25th 1940. Death is said to have occurred on the date stated above, at 10 P. m.

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

Myocarditis

Influenza

Other contributory causes of importance: 93A

Date of onset 3

2/18/40

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Edwin Shouse, M. D.

(Address) Lawson, Mo.

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.

RECEIVED

District Health Officer No. 111

District File Number 370-360

Date Filed MAR 13 1940

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6111

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 99

Primary Registration District No. 2147

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Caldwell
(b) City or town Rockford
(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)

3. (a) PRINT FULL NAME Albert Richard Hitchings

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased Dec 14 1898
(Month), (Day) (Year)

8. AGE: Years Months Days If less than one day
41 2 11 hr. min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Mar. 1 - 40 (b) Mrs. Wylie O. Thompson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell
(c) City or town Rural
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

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) Means of injury _____

23. Signature Edwin Shaw or other _____

Address Lawson Date signed _____

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

SUPPLEMENTAL COPY

