

X21492

FILED MAP 1/5/40

Registration District No. \_\_\_\_\_

Primary Registration District No. 4090

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Cass  
 (b) City or town Harrisonville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution Harrisonville Hospital  
(If not in hospital or institution, write street number & location)  
 (d) Length of stay: In hospital or institution 1 day  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass  
 (c) City or town Crighton Mo.  
(If outside city or town limits write "RURAL")  
 (d) Street No. 0  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME LAWRENCE E. HUME WHITSITT

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, Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
alive years

7. Birth date of deceased Nov 10 1931  
(Month) (Day) (Year)

8. AGE: Years 8 Months 3 Days 10 If less than one day \_\_\_\_\_  
hr. min.

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

10. Usual occupation in school

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

MOTHER FATHER { 12. Name Andrew B. Whitsitt  
 18. Birthplace Harrisonville Mo.

MOTHER FATHER { 14. Maiden name Stella Marie Whitsitt  
 15. Birthplace Harrisonville Mo.

16. (a) Informant Mrs. A. B. Whitsitt  
 (b) Address Crighton Mo.

17. (a) Orient Cemetery (b) Date thereof 2-22-40  
(Burial, cremation, or other) (Month) (Day) (Year)  
 (c) Place: burial or cremation Orient Cemetery

18. (a) Signature of funeral director HUNNENBURGER'S  
 (b) Address HARRISONVILLE, MO.

19. (a) 2-24-40 (b) Beckensly R. D.  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 30  
 year 1940 hour 6:32 minute P M.

21. I hereby certify that I attended the deceased from Feb 20  
1940 1940 to Feb 20 1940  
 that I last saw him live on Feb 20 - 40  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
 Duration \_\_\_\_\_

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

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

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy no

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) no  
 (b) Date of occurrence no  
 (c) Where did injury occur? no  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury no

23. Signature God [unclear] (M. D. or other) \_\_\_\_\_  
 Address Garden City Date signed 2-24-40

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

Dr Geo Griffith

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**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 Ernest R. Remmenburg

Licensed Embalmer No. 3368

P. O. Address Harrisonville

**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. **6246**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **156**

Primary Registration District No. **4090**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Cass**  
(b) City or town **Harrisonville mo**  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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.

3. (a) DECEASED'S FULL NAME

**Lawrence Home Whitsett**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **20**  
year **1960** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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 **s**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years **8** Months **3** Days **10** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death: **pneumonia bronchial**

Due to: **following influenza**

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

Major findings: Of operations: **na**

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

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: **Geo. W. Griffith** (M. D. or other) \_\_\_\_\_

Address: **Garden City mo** Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

