

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 477

Primary Registration District No. 5646

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Dickerson
(c) Name of hospital or institution: County Home
(If not in hospital or institution, write street number or location) 3
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John M. Hutchison

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

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

7. Birth date of deceased Mar 11 1846
(Month) (Day) (Year)

8. AGE: Years 93 Months 11 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business Farmer

12. Name John Hutchison

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

14. Maiden name Ella Murphy

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

16. (a) Informant's own signature Hutchison

(b) Address Farming Mo

17. (a) _____ (b) Date thereof Mar 12-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Daven

18. (a) Signature of funeral director Thomas Ball

(b) Address Farming Mo

19. (a) Mar 12-1940 (b) H. W. Harris
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10 year 1940 hour 9 minute 30 p. M.

21. I hereby certify that I attended the deceased from Mar 1 1940 to Mar 10 1940
that I last saw him alive on Mar 10 1940
and that death occurred on the date and hour stated above.

Immediate cause of death uremic poisoning Duration Mar 10 to Mar 10
Due to retention of uric acid due to enlarged prostate
Due to _____

Other conditions semility and general weakness
(Include pregnancy within 3 months of death)

Major findings: 137
Of operations _____
Of autopsy _____

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? 435
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Thomas P. Ball (M. D. or other) MD
Address Dickerson Date signed Mar 12

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

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. 10

District File Number: 4-40-795

Date Filed: APR 9 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: *Thomas Ball*

Licensed Embalmer No. 1744

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. 11554

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 477

Primary Registration District No. 2646

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Lewis

(b) City or town Dixon Ill

(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)

3. (a) PRINT FULL NAME John M. Hutchison

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 Widowed

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 93 Months 11 Days 29 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) May 6, 1940 (b) H. W. Harris M.D. (Date of local registrar) (Registrar's signature)

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

20. DATE OF DEATH Month May day 10 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) (e) Means of injury.....

23. Signature Harry L. McCrae (M.D. or other) Physician Address..... Date signed.....

SUPPLEMENTAL

11554 (1940)