

Registration District No. 527

Primary Registration District No. 57-03 4313

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County MACON  
(b) City or town Bevier  
(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) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County MACON  
(c) City or town Bevier  
(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) PRINT FULL NAME WM. THOMAS WHITAKER

(b) If veteran, name war \_\_\_\_\_ (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 JUNE 26 1866  
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation COAL MINER

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

MOTHER FATHER { 12. Name John Westacy Whitaker  
18. Birthplace KENTUCKY  
(City, town, or county) (State or foreign country)  
14. Maiden name DORA B. HURT  
15. Birthplace CHARITON CO MO  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. Gus OSMAN  
(b) Address Bevier Mo  
17. (a) BURIAL (b) Date thereof 3-8-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bevier Mo

18. (a) Signature of funeral director W. L. Edwards  
(b) Address Bevier Mo  
19. (a) 4-10-1940 (b) Edw. Simpson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 7th  
year 1940 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb 17, 1940, to March 7th, 1940  
that I last saw him alive on Mar 5, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Gangrene of foot & leg  
Due to Arterio sclerosis  
Duration Feb 1 1940 1935

Other conditions 97  
(Include pregnancy within 3 months of death)

Major findings:  
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? 470

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature J. F. Turner (M. D. or other) \_\_\_\_\_  
Address MACON MO Date signed 3/9/40

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

RECEIVED

District Health Officer No. 10

District File Number 4-40-813.

Date Filed APR 11 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 \_\_\_\_\_

H. E. Edwards, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed H. E. Edwards

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.