

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

12644

APR 23 1940

1. PLACE OF DEATH
County Stone Registration District No. 1096
Township Flat Creek Primary Registration District No. 6247
City Cape Fair (No. 3511) St. _____ Ward _____
2. FULL NAME James Withnell 20
(a) Residence. No. Stone Co Rural 0 Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. _____
Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 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 Martha Withnell
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12 - 1867
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 3 7
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9
10. NAME OF FATHER Thomas Withnell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Webb City, Mo. 0
12. MAIDEN NAME OF MOTHER Annie Hogg
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 19 1940
17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1940 to Mar 19 1940
that I last saw him alive on Jan 25 1940, and that death occurred, on the date stated above, at _____ m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute Endocarditis
92C
CONTRIBUTORY (SECONDARY) Chrom. Myocarditis (duration) _____ yrs. _____ mos. _____ ds.
3 yrs. _____ mos. _____ ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH X
DID AN OPERATION PRECEDE DEATH X DATE OF _____
WAS THERE AN AUTOPSY No
WHAT TEST CONFIRMED DIAGNOSIS aut
(Signed) J. J. [Signature] M. D.
, 19 (Address) Stone Co Mo
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT Opal Rawlins
(Address) Cape Fair, Mo
15. FILED 4/5 40 L. H. Keery 750
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cape Fair DATE OF BURIAL Mar 19 1940
20. UNDERTAKER Manlove funeral Home ADDRESS Crane Mo

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

APR 8 1940
Date Filed

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

File No.
Registered No.
St. Ward)

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No..... St. Ward)

2. FULL NAME.....

(a) Residence. No..... St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT.....
(Address)

15. FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19.....
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20. UNDERTAKER	ADDRESS
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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.