. S. No. 2
1—11-10-39
ev. 3-17-39
I X21492

51

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25508

Registration District No. 726 Primary Registration District No. 4252 Registrar's No. 12

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Chilhowee 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 years, months or days)
In this community 70 yrs 365

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Johnson
(c) City or town Chilhowee Mo
(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 Zach T Kitterman
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 married
6. (b) Name of husband or wife Rosa B. Kitterman
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased 9 (Month) 9 (Day) 1861 (Year)

8. AGE: Years	Months	Days	If less than one day
78	10	10	hr. min.

9. Birthplace (City, town, or county) Indiana (State or foreign country)
10. Usual occupation Farming
11. Industry or business
12. Name John Wesley
13. Birthplace Unknown (City, town, or county) Indiana (State or foreign country)
14. Maiden name Sarah C. Smith
15. Birthplace Unknown (City, town, or county) Indiana (State or foreign country)
16. (a) Informant Rosa B Kitterman
(b) Address Chilhowee Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21-40 (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Grove
18. (a) Signature of funeral director Fred C. Wilkinson
(b) Address Clinton Mo
19. (a) July 20-40 (Date received local registrar) (b) O. L. Leach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1940 hour 7:12 minute 45 A.M.
21. I hereby certify that I attended the deceased from July 13, 1940, to July 18, 1940; that I last saw him alive on July 18, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Cerebral Hemorrhage
Due to Arterio Sclerosis
and Myocardial degeneration
Due to
Other conditions
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature G. M. Kendall (M. D. or other) M.D.
Address Chilhowee Mo Date signed 7/20-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-7-40

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 William K. Jackson

Licensed Embalmer No. 3954

P. O. Address Clinton Iowa

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.