

ALL SET 21 1937

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

Do not use this space.

30048

1. PLACE OF DEATH

County Wright Registration District No. 908 ✓  
Township Wm. Lane Primary Registration District No. 6222  
City 324 Rex Mission Hitchcock (No. ....) St. .... Ward) (No. ....) Ward)

File No. ....  
Registered No. 46

2. FULL NAME

(a) Residence, No. .... St. .... Ward. (If nonresident, give city or town and State)  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-25-1922

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
14 11 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School boy  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Buckhart Mo

MOTHER 13. NAME James Hitchcock

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Douglas Co Mo

15. MAIDEN NAME Lawson Hurst

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Douglas Co Mo

17. INFORMANT (ADDRESS) Ruby Keeler

18. BURIAL, CREMATION, OR REMOVAL PLACE Hurst Cem DATE 5-4-37

19. UNDERTAKER (ADDRESS) Wue

20. FILED 8-25 19 40 Bureau Wright Mo

MEDICAL CERTIFICATE OF DEATH

7-5a

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/4-1937 19

22. I HEREBY CERTIFY, That I attended deceased from 3/2 - 1937, to 5/4 1937

I last saw him alive on 5/3 1937. Death is said to have occurred on the date stated above, at 7:30 m.

The principal cause of death and related causes of importance were as follows:

Gun shot wound (accidental) Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) R. A. Ryan, M. D.

(Address) Wm. Lane

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.

1 20314

RECEIVED

District Health Officer No. 6,

District File Number.....

Date Filed..... **SEP 17 1944**.....

184/17

2B  
1-40  
X22659

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **30048**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **908**

Primary Registration District No. **6222**

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

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

1. PLACE OF DEATH:  
 (a) County **Wright**  
 (b) City or town **Mountain Grove, 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 \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Mo** (b) County **Wright**  
 (c) City or town **Mountain Grove**  
 (If outside city or town limits write "RURAL")  
 (d) Street No. **Rural**  
 (If rural, give location)  
 (e) If foreign born, how long in U.S.A.?  \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Ray Miron Hitchcock**  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **5** day **14** year **1937** 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 \_\_\_\_\_

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 \_\_\_\_\_ year

Duration  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

7. Birth date of deceased: (Month) (Day) (Year)  
 8. AGE: Years Months Days If less than one day  
**14 11 9** \_\_\_\_\_ min.

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

9. Birthplace: (City, town, or county) (State or foreign country)  
 10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 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 \_\_\_\_\_

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 \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 19. (a) **10-29-40** (b) **Berrie Metzger**  
 (Date received local registrar) (Registrar's signature)

23. Signature **R. P. Ryan** (M. D. or other) \_\_\_\_\_  
 Address **Mountain Grove Mo** Date signed \_\_\_\_\_

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **30048**  
Registrar's No. **46**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **908**

Primary Registration District No. **6222**

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

1. PLACE OF DEATH:  
(a) County **Worth**  
(b) City or town **Worth**  
(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  
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Rep Dixon Hatchesek**  
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

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

8. AGE: Years Months Days If less than one day  
**14 11 9**

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name  
13. Birthplace (City, town, or county) (State or foreign country)

{ 14. Maiden name (City, town, or county) (State or foreign country)  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)  
(Burial, cremation, or removal)

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

19. (a) (b) (Date received 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 **5** - day **4** year **1937** hour minute M.  
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 **gun shot wound, accidental** Duration **2 days**  
**27 caliber rifle while hunting with a neighbor boy.**  
Due to **184 17**  
Due to  
Other conditions (Include pregnancy within 3 months of death)

Major findings: **Bullets fired in several places to bladder**  
Of autopsy **fired**  
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 **5/4 - 1937**  
(c) Where did injury occur? **dean platt - mo** (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **at home while hunting**  
While at work? **hunting** (Specify type of place) (e) Means of injury  
23. Signature **R. A. Ryan** (M. D. or other)  
Address **mta glauc** Date signed **1937-5-4**

SUPPLEMENTAL