DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

NOV 20 1940

State File No. 35645

Registration District No. 429 Primary Registration District No. 3684 Registrar's No.

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

X21492

1. PLACE OF DEATH:

(a) County Johnson

(b) ~~City or town~~ Rural, Washington (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2 (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 Missouri (b) County Johnson

(c) City or town Rural (If outside city or town limits write "RURAL")

(d) Street No. Washington Township (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Samuel Austin Whitehead

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex male

5. Color or race white

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 December (Month) 3 (Day) 1856 (Year)

8. AGE: Years 83 Months 9 Days 28 If less than one day hr. min.

9. Birthplace De Soto (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Retired 0

11. Industry or business 0

FATHER
12. Name John Whitehead
13. Birthplace De Soto (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Sarah States
15. Birthplace De Soto (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mary C. Cook

(b) Address Knob Noster, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1 (Month) (Day) 1940 (Year)

(c) Place: burial or cremation Knob Noster City Cemetary

18. (a) Signature of funeral director C. L. Saults

(b) Address Knob Noster, Mo.

19. (a) Oct 1-1940 (Date received local registrar) (b) J. A. Koch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1st year 1940 hour 8 minute 30 a M.

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

Immediate cause of death (1) Chr myocarditis

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? 389 (Specify type of place)

While at work? ✓ (e) Means of injury ✓

23. Signature [illegible] (M. D. or other) 1

Address Knob Noster, Mo. Date signed Oct 3

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number 11-8-140
Date Filed

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.