

Registration District No. **875**

Primary Registration District No. **6162**

Registrar's No. **256**

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Rural, Washington Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp #3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 1/2 to 10 days
(Specify whether: 0)
In this community unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Newton
(c) City or town unknown
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 16
year 1940 hour 40 minute 0 M.

21. I hereby certify that I attended the deceased from 1-25, 1939, to 10-16, 1940
that I last saw him alive on 10-16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis

Due to _____
Due to _____

Other conditions: Senility
(include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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?
795
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address State Hosp #3 Date signed 19/16/40

Duration
Physician
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME George W. Whitman

8. (b) If veteran: name war no 8. (c) Social Security No. none

4. Sex M 5. Color or race W 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 8-13-1857
(Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
12. Name George W. Whitman
13. Birthplace unknown Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Pitcher
15. Birthplace unknown Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital #3 Records
(b) Address _____

17. (a) Burial (b) Date thereof 10-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director Allen V. Hays
(b) Address Nebraska Mo

19. (a) 10-16-40 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

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

8

RECEIVED

District Health Officer No. 7,

District File Number 11-40-1524

Date Filed 11-4-40

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 _____

Not Embalmed, 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 with the above constitutes grounds for revocation of license.)

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