

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

43668
Do not use this space.

FILED JAN 25 1941

1. PLACE OF DEATH
(a) County Reynolds Registration District No. 746
(b) Township Jackson Primary Registration District No. 5981
(c) City Jackson (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah Chitwood
(a) Residence, No. Reynolds co., Mo St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (widowed)
A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-20-1871
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 6 25
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
9. Industry or business in which work was done, as saw mill, bank, etc. her home
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) Reynolds co., Mo

FATHER 13. NAME Moses Mc Nail

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Reynolds co., Mo

MOTHER 15. MAIDEN NAME Rebecka Mills

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Reynolds co., Mo

17. INFORMANT (ADDRESS) William Chitwood

18. BURIAL, CREMATION, OR REMOVAL PLACE Pogue Cemetery DATE Nov. 7, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rev. Pennington

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 5, 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1940, to Nov. 5, 1940

I last saw her alive on Oct. 31, 1940 Death is said to have occurred on the date stated above, at 10:00 P.M.

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

Paralysis of left side

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? no

If so, specify (Signed) L. L. Henson M. D.
Bunker, Mo. (Address)

Local Registrar

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.

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RECEIVED

District Health Officer No. 5,

District File Number. 17401208

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 with the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43668

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 746

Primary Registration District No. 5981

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Jackson T.P.
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Sarah Chitwood

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years 69 Months 6 Days 25 If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

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 (Month) (Day) (Year)

(c) Place: burial or cremation _____

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 Nov day 5 year 1940 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 paralysis of left side cerebral hemorrhage

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) g2h

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43668

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 246

Primary Registration District No. 5981

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Jackson
(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.
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Sarah Chitwood

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife.

6. (c) Age of husband, or wife, if alive. year

7. Birth date of deceased

JUNE (Month)

30 (Day)

1871 (Year)

8. AGE:

Years

Months

Days

If less than one day

69

6

25

h. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER { 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

18. (a) Signature of funeral director

(b) Address

19. (a) Mar 5 1941

(Date received local registrar)

(b) Mar 8 J Purtle

(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 5 year 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

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?

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

23. Signature L. L. Benson (M. D. or other)

Address Bunker, Mo Date signed

SUPPLEMENTAL