

JAN 25 1941  
Registration District No. 763

Primary Registration District No. 6458

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Louevry City  
(c) Name of hospital or institution Jackson Lwp  
(d) Length of stay: In hospital or institution Hours  
In this community 40 yrs

3. (a) PRINT FULL NAME GEORGE WILLIAM WITTY  
3. (b) If veteran, name war non  
3. (c) Social Security No. non

4. Sex Male 5. Color of race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Anna Johnson  
6. (c) Age of husband or wife if alive 74 years  
7. Birth date of deceased Feb. 12 - 1864

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>10</u>	<u>4</u>	hr. _____ min.

9. Birthplace Benton Co Ark

10. Usual occupation Real Estate Agt

11. Industry or business Insurance

12. Name Thomas Witty

13. Birthplace Benton Co Ark

14. Maiden name Sarah Fawcett

15. Birthplace unknown

16. (a) Informant Mable Park

(b) Address Deepwater Mo

17. (a) Burial (b) Date thereof Dec 18, 1940

(c) Place: burial or cremation Appleton City Mo

18. (a) Signature of funeral director Frank Lee

(b) Address Appleton City Mo

19. (a) 12/17/40 (b) Sophia Stratton

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County St. Louis  
(c) City or town Louevry City  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 16  
year 1940 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from December 9, 1940, to December 16, 1940  
that I last saw him alive on December 16, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hydrostatic Pneumonia 1 day

Due to: Prolonged bedfastness 2 days

Due to: Senility

Other conditions: Paralysis of Larynx

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

(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 3

23. Signature J. W. Kerry (M. D. or other) Dr.

Address Louevry City Mo Date signed 12/17/40

82B

RECEIVED

District Health Officer No. 7,

District File Number 1-41-47

Date Filed 1-9-41

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 ME

on the 16th day of Dec. 1940

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

Frank Lee

Licensed Embalmer No. 1099

P. O. Address Appleton City W

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. 43714

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 763

Primary Registration District No. 6458

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

1. PLACE OF DEATH

(a) County St. Clair  
(b) City or town Louisy City  
(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 \_\_\_\_\_ (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.

3. (a) PRINT FULL NAME

Geo. Wm. Watty

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 M

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive 74 years

7. Birth date of deceased April (Month)

12 (Day) 1864 (Year)

8. AGE:

Years 76 Months 10 Days 4

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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 \_\_\_\_\_  
(Burial, cremation, or removal) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 16  
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 \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia

Due to Prolonged bed fastness  
Cerebral Hemorrhage

(Other conditions Paralysis of Larynx  
(include pregnancy within 3 months of death)  
due to cerebral hemorrhage, which  
Medicaid paralyzed **PHYSICIAN**

Of operations \_\_\_\_\_  
Of autopsy g.w.  
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 A. M. Berry (M.D. or other) DO  
Address Louisy City Date signed 2/19/41

SUPPLEMENTAL

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

