

APR 13 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

11808

Registration District No.

734

Primary Registration District No.

5964

Registrar's No.

51

## 1. PLACE OF DEATH:

(a) County RANDOLPH  
 (b) City or town RE-NICK - RURAL  
 (c) Name of hospital or institution: 1 Prairie  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 (Specify whether)  
 In this community Life time  
 years, months or days

3. (a) PRINT FULL NAME THOMAS WALTER HITT3. (b) If veteran, name war  3. (c) Social Security No.4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife EDNA PEARL HITT 6. (c) Age of husband or wife if alive 60 years7. Birth date of deceased. (Month) MAY (Day) 31 (Year) 18718. AGE: Years 69 Months 9 Days 21 If less than one day hr. 1 min.9. Birthplace Howard Co. MO (City, town, or county) (State or foreign country)10. Usual occupation FARMER

11. Industry or business

12. Name J. W. HITT13. Birthplace VA (City, town, or county) (State or foreign country)14. Maiden name ELLEN KILBY15. Birthplace VA (City, town, or county) (State or foreign country)16. (a) Informant WIFE EDNA P. HITT(b) Address RENICK MO.17. (a) BURIAL (b) Date thereof 3 25 41 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation CHAPEL GROVE - CLARK18. (a) Signature of funeral director Paul T. Mackay(b) Address Mobile, Missouri19. (a) March 25 (b) 191 1st Kansas Ave (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County RANDOLPH  
 (c) City or town RENICK - RURAL  
 (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.? 10 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 21 year 1941 hour 6 minute 9 M.21. I hereby certify that I attended the deceased from Jan 1 - 15 40 1940 to Mar 21 1941that I last saw him alive on Mar 20 1941 and that death occurred on the date and hour stated above.Immediate cause of death Heart failure

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) Rheumatoid

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? 63

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

23. Signature R. A. Mackay (M. D. or public health officer)Address Clark Mo Date signed 3-27-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

2002

RECEIVED

District Health Officer No. 10

District File Number 4-41-708

Date Filed APR 10 1941

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

working under my personal supervision.

Registered Apprentice No.

Signed

*Percy T. Hackney*

Licensed Embalmer No.

*35981*

P. O. Address

*Marble Mission*

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, fact should be so stated above.

No. 2  
-1-4-41  
-17-30  
25590

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

# MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 11808

Registration District No. 736

Primary Registration District No. 5964

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

### 1. PLACE OF DEATH:

(a) County Randolph  
 (b) City or town Pearce, 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

3. (a) PRINT FULL NAME Thomas Walton Hitt  
 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 W  
 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 9 Days 21  
 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 \_\_\_\_\_  
 { 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) 3-29-1941 (b) 99 Kinship  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 21  
 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw him \_\_\_\_\_ alive or \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
 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 R. D. Howels (M. D. or other) \_\_\_\_\_  
 Address Clark Date signed \_\_\_\_\_

**SUPPLEMENTARY**

(Licensed Embalmer's Statement on Reverse Side)

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11808

Registration District No. 736

Primary Registration District No. 5964

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

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

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Prairie Twp  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Thomas Melton Hett

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: month Mar day 21  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

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 \_\_\_\_\_ year

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

Immediate cause of death Heart failure Duration \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

69 9 21

Due to Myocardial Infarction

Due to \_\_\_\_\_

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

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

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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)

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 R A Woods (M. D. or other) \_\_\_\_\_

Address Clark Mo Date signed 5-6-41

SUPPLEMENTAL 1941

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