No. 2
-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 25 1941

Registration District No. 89

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24639

Primary Registration District No. 3007

Registrar's No. 308

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Poplar Bluff Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Hosp. 4 hrs (Specify whether In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103

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

(d) Street No. South of Dexter. Route 4 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Otto Junior Whitehead

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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 Dec. (Month) 25 (Day) 1923 (Year)

8. AGE: Years 17 Months 7 Days 7 If less than one day hr. min.

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

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Otto Whitehead
13. Birthplace Stoddard Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Mae Long
15. Birthplace Stoddard Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Otto Whitehead

(b) Address Dexter, Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 8-2-41 (Month) (Day) (Year)

(c) Place: burial or cremation Bernie Cemetery

18. (a) Signature of funeral director Blankenship-Strickland

(b) Address Dexter, Mo.

19. (a) 8-5-41 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2 year 1941 hour 6 minute 40 a M.

21. I hereby certify that I attended the deceased from August 2, 1941, to August 2, 1941; that I last saw him alive on August 2, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Concussion of brain - Laceration of scalp

Due to

Due to

Other conditions Compound fracture lifthumerus (Include pregnancy within 3 months of death) Hemorrhage

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) Accident 103

(b) Date of occurrence 8-2-1941

(c) Where did injury occur? Dexter (City or town) - Stoddard (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway #35 - 4 miles South of Dexter (Specify type of place)

While at work? (e) Means of injury

23. Signature J. M. Hinrickson (M. D. or other) D

Address Poplar Bluff Mo Date signed 8-3-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 841-1125
Date Filed 8-19-41

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~~ J. E. Strickland, ~~Registered Apprentice No.~~ working under my personal supervision.

Signed J. E. Strickland

Licensed Embalmer No. 3479

P. O. Address Dexter, Mo

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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24639

Registration District No. 89 Primary Registration District No. 3007 Registrar's No. 308

1. PLACE OF DEATH

(a) County Butler

(b) City or town Poplar Bluff
(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 years, months or days)
In this community

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 Otto J. Whitehead

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 S

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 Months Days 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day year 1941 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 — Duration
Concussion of brain
Laceration of skalp
Due to Caused from this automobile colliding.
Due to

Other conditions. Compound fracture of left humerus - Hemorrhage
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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) Accident on highway
(b) Date of occurrence 8-2-1941
(c) Where did injury occur? Dexter (City or town) Stoddard (County) Mo (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? Hgh #35 - 4 mi S of Dexter (Specify type of place)
While at work? (e) Means of injury

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

SUPPLEMENTARY

S. No. 2B
I—8-21-41
I X29288

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Registration District No. B 89 Primary Registration District No. 3007 Registrar's No. 308

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Poplar Bluff Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hrs (Specify whether
In this community ~~4 hr~~ 4 HRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard

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

(d) Street No. South of Dexter - Route 4
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Otto J. Whitehead

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 S

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 | Months | Days | 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 9-15-41 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day year 1941 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (c) Means of injury

23. Signature (M. D. or other)

Address Date signed