

FILED NOV 11 1942

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

Do not use this space.

35082

1. PLACE OF DEATH

County Vernon
Township Walker
City Walker (No. 0)

Registration District No. 358
Primary Registration District No. 9524

File No. 108
Registered No. 67
St. 0 Ward 0

2. FULL NAME

William Maxie Tuttle
(a) Residence, No. 1 St. 0 Ward 0
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 14 1861
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 7 21

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 1937
11. Total time (years) spent in this occupation 27

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Troy Mo13. NAME James H Tuttle14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co Mo15. MAIDEN NAME Mastry Boone16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky17. INFORMANT Mrs Emma C Tuttle
(ADDRESS) Walker Mo18. BURIAL, CREMATION, OR REMOVAL
PLACE Newton DATE Oct 6 194219. UNDERTAKER D. W. Waggoner
(ADDRESS) Starved20. FILED 10-6 1942 Ruby Blum
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 5 194222. I HEREBY CERTIFY, That I attended deceased from June 1938, to Oct 5 1942I last saw him alive on Oct 4 1942 Death is saidto have occurred on the date stated above, at 3:30 A.M.

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

Carcinoma of Rectum
Date of onset
H68

'Other contributory' causes of importance:

Name of operation Prostatectomy Date of 10/5/42
What test confirmed diagnosis? Microscopic Was there an autopsy? no23. 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) C. B. Davis, M. D.
(Address) Walker Mo

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.

RECEIVED

District Health Officer No. 7,

District File Number 11-42-1888

Date Filed 11-9-42

This is to certify that I embalmed the body of the person whose name appears on other side of sheet.

Signed *O. W. Wagner*

License No. 2709

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35092

Registration District No. 358

Primary Registration District No. 4524

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Verona
(b) City or town _____
(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 MO (b) County Verona
(c) City or town Walker
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William M. Tuttle

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 _____ years
7. Birth date of deceased Feb 14 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 10 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____
(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 5 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, _____, 19____; 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 _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

35082