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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 4 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5312

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 853

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution 26 days (Specify whether years, months or days)

In this community 26 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jay

(c) City or town Higginsville
(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 John J. Littlejohn

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18
year 1943 hour 7:00 minute P.M.

21. I hereby certify that I attended the deceased from _____ 19____ to Feb 18 1943;
that I last saw h. _____ alive on Feb 18 1943;
and that death occurred on the date and hour stated above.

4. Sex M 5. Color of hair brn

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

6. (b) Name of husband or wife Elizabeth 6. (c) Age of husband or wife if alive unk years

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

Immediate cause of death Broncho-pneumonia

Due to General arterio-sclerosis
& cerebro-vascular accident

Due to 82a

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

8. AGE: Years 75 Months 2 Days 0
If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Robert P. Littlejohn

13. Birthplace Adellville Mo
(City, town, or county) (State or foreign country)

14. Maiden name Silvan Perdue

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

PHYSICIAN _____

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant R. A. Littlejohn

(b) Address Higginsville, Mo

17. (a) Removal (b) Date thereof 2-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Mo

18. (a) Signature of funeral director W. M. Crowe

(b) Address Higginsville Mo

19. (a) 7/8/43 (b) W. M. Crowe
(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)

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 0

23. Signature Dr. R. C. Davis W. M. Crowe M.D.
(M. D. or other)

Address _____ Date signed 2-18-43

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

361

(Licensed Embalmer's Statement on Reverse Side)

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

Forrest A. Hoyle

Registered Apprentice No.

336

working under my personal supervision.

Signed

Forrest A. Hoyle

Licensed Embalmer No.

5391

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, fact should be so stated above.