

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33332**FILED DEC 10 1943
Registration District No. **4**Primary Registration District No. **5863**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Oregon**
 (b) City or town **Couch Oak Grove 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 **12 years** (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME **Andrew Whitwell**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, **Married**6. (b) Name of husband or wife **Ida Staggs** 6. (c) Age of husband or wife if alive **65** years7. Birth date of deceased **April 10 1863**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
80 6 11 .hr. .min.9. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **Unknown**13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)14. Maiden name **Unknown** **9**
(City, town, or county) (State or foreign country)15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)16. (a) Informant **Delbert Oliver**(b) Address **Couch, Mo.**17. (a) **Burial** (b) Date thereof **10/23/43**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Cotton Creek Cem.**18. (a) Signature of funeral director **None**

(b) Address

19. (a) **10-10-43** (b) **Jae W Williams**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Oregon** **75**
 (c) City or town **Couch (Rural)**
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? (Yes or No) **0**
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **21**
year **1943** hour **10** minute **30** A. M.21. I hereby certify that I attended the deceased from **March -43**
1943 to **Oct 21**, 1943;
that I last saw him alive on **Oct Oct 21**, 1943;
and that death occurred on the date and hour stated above.Immediate cause of death **Cerebral Hemorrhage** **4 hrs**
DurationDue to **High Blood pressure & Cancer** **4 yrs**

Due to

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operationsOf autopsy **NO**

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) **NO**
 (b) Date of occurrence **NO**
 (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 **W. Williams** (M. D. or other) **W**
Address **Altam. Mo** Date signed **11/21/43**

RECEIVED

District Health

Office No. 5,

District File No.

1243406

Date Filed

12-9-43

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Rural
(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 12 yr (years, months or days)

3. (a) PRINT FULL NAME Andrew Whitnell
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 _____ year

7. Birth date of deceased april 10 1906
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days _____ If less than one day _____ min.

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

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)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 October year 1943 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: Cerebral hemorrhage Duration 3 hours

Due to: high blood pressure
Cancer of ear & floor of mouth 60-64 years

Due to: of throat
this hemorrhage was supposed to be in his throat 53

Other conditions: _____ (Include pregnancy within 3 months of death)
Major findings: that when it occurred
Operations: I do not know

Of autopsy: has been necropsy

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 Dr. Whitnell (M. D. or other) _____
Address Adrian Ave Date signed _____

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

SUPPLEMENT

38832