

Registration District No. 165

Primary Registration District No. 5102

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Johnson
 (b) City or town Rural (Chilhowee Twp)
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Chilhowee Twp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution none
(Specify whether
 In this community 45 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 6 miles South of Holden, Mo
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country XXX

3. (a) PRINT FULL NAME LILLIAN B. HITE

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife James W. Hite 6. (c) Age of husband or wife if alive dec'd years
 7. Birth date of deceased April 64 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>11</u>	<u>18</u>	hr. _____ min.

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

10. Usual occupation housewife
 11. Industry or business at home

12. Name D. W. Manning
 13. Birthplace Sandusky, Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name Francis B. Greenland
 15. Birthplace Cassville, Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant Wilford Hite
 (b) Address Holden, Missouri.
 17. (a) Burial (b) Date thereof 3/27/44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New Liberty Cemetery
 18. (a) Signature of funeral director Canaday and Ropp
 (b) Address Holden, Missouri.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
 year 1944 hour 6:50 minute _____ P. M.

21. I hereby certify that I attended the deceased from June 4
 1939, to March 24 1944;
 that I last saw her alive on March 24 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death
Arteriosclerotic Nephritis
Chronic Myocarditis

Due to _____
 Due to _____
 Other conditions Diabetes Mellitus
(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)
 _____ (e) Means of injury _____

23. Signature Kelly Rawlin (M. D. or other) _____
 Address Holden, Mo Date signed 3/28/44

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

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

MOTHER FATHER

862

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..... *M. L. Canaday*
Licensed Embalmer No. *3434*
P. O. Address *Holden 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 165

Primary Registration District No. 5602

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Chilhowitz
(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 Lillian B. Hite

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 April 6 (Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days _____ If less than one day _____ min.

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

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/13/1944 (b) M. O. P. O. O. O. (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 March year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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

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)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

11295