

S. No. 2
FORM-5-43
Rev. 5-17-39
- 1 X3687

13959

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 92

FILED MAY 19 1944
Registration District No. _____

Primary Registration District No. 3000

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

1. PLACE OF DEATH:

(a) County Adair

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

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

(d) Length of stay: In hospital or institution Nine days
(Specify whether Life)

In this community Life
(years, months or days)

3. (a) PRINT FULL NAME Lov Avis Truitt

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Dannie Truitt

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased May 26 1915
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>28</u>	<u>11</u>	<u>1</u>	hr. _____ min. _____

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

10. Usual occupation Home

11. Industry or business _____

12. Name S. C. Pipes

13. Birthplace Browning Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Orpha Truitt

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

16. (a) Informant S. C. Pipes

(b) Address Novinger, Missouri

17. (a) Burial (b) Date thereof 4/30/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greencastle, Mo.

18. (a) Signature of funeral director D. R. Kelly

(b) Address Kirkville, Missouri

19. (a) 5/1/44 (b) Mrs. J. W. Wagner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

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

(d) Street No. Rural
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1944 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from Apr 19-
1944 to Apr 27- 1944
that I last saw her alive on Apr 27- 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Heart block

Due to _____

Due to 56d

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

Major findings:
Of operation Fracture of the intervertebral disc

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) _____

(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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature R. R. Ellis (M. D. or other) _____
Address Kirkville, Mo. Date signed 4-28-44

1049

1-44-848

MAY 9 1944

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..... *B. E. Riley*

Licensed Embalmer No..... *4181*

P. O. Address..... *Ham Kettle W*

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.