

FILED JUL 13 1944 7

Primary Registration District No. 3023

Registrar's No. 96

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

1. PLACE OF DEATH:

(a) County Hannay
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Clinic Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 0 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Clair
(c) City or town Callins (Rural)
(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 Marion Truitt

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

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased June 10 1866
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 25 hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Elika Truitt
13. Birthplace Illinois (City, town, or county) (State or foreign country)

14. Maiden name Miranda Robinson

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

16. (a) Informant Perry Truitt
(b) Address Callins Mo.

17. (a) Callins (b) Date thereof 6-7-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson Care

18. (a) Signature of funeral director Oscala J. Home
(b) Address Oscala Mo.

19. (a) June 5, 1944 (b) Georgia Kitchen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5
year 1944 hour 11:30 minute _____ M.
21. I hereby certify that I attended the deceased from June 2
1944 to June 5, 1944
that I last saw him alive on June 5, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Strangulated hernial loop
toxicemia - from above.

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)
(e) Means of injury _____
23. Signature Joseph B. Wall (M. D. or other) M.D.
Address Callins Mo. Date signed 6-5-44

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

12282

RECEIVED

District Health Officer No. 71

District File Number 6-44-813

Date Filed 7-11-44

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 Paul F. [Signature]

Licensed Embalmer No. 3990

P. O. Address [Signature]

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.