

FILED OCT 13 1944

Registration District No. **22**

Primary Registration District No. **3072**

Registrar's No. **170**

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

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
581 S. Jefferson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline 97
(c) City or town Marshall 1
(If outside city or town limits, write "RURAL")
(d) Street No. 581 S. Jefferson
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EUGENE GAUNT KITCHEN

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

4. Sex m 5. Color or race w 6. (a) Single, married, divorced married
6. (b) Name of husband or wife Fannie Thorp Kitchen 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Sept - 2 - 1863
(Month) (Day) (Year)

8. AGE: Years 81 Months 0 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Saline Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name James C Kitchen
13. Birthplace King, I
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Catherine Gaudin
15. Birthplace Saline Co mo
(City, town, or county) (State or foreign country)

16. (a) Informant Fannie Thorp Kitchen
(b) Address Marshall mo

17. (a) Burial (b) Date thereof 9-29-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int Carmel Cm, Saline Co mo

18. (e) Signature of funeral director Harry Hershberger

(b) Address Marshall mo

19. (a) 9/27/1944 (b) Mat Woodhams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27
year 1944 hour 9 minute 45 A. M.

21. I hereby certify that I attended the deceased from Sept 27 1944
20 to Sept 27 1944
that I last saw him alive on Sept 27 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage 3 days
Due to _____

Due to arterial Sclerosis 10 yrs
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 [Signature] (M. D. or other) _____
Address [Signature] Date signed 9/27/44

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

16-12-44

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 _____

Harry Hershberger

Licensed Embalmer No. _____

4357

P. O. Address _____

Marshall 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.