

UNITED STATES BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38543**
Registrar's No. **364**

Registration District No. **2**

Primary Registration District No. **2052**

1. PLACE OF DEATH: **Pettis**
(a) County
(b) City or town **Sedalia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
228 West Saline
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **35 years** (Specify whether years, months or days)
In this community

3. (a) PRINT FULL NAME **Elizabeth B. Whitworth**
3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **David Whitworth** 6. (c) Age of husband or wife if alive **(deceased)** years
7. Birth date of deceased **May 4, 1860**
(Month) (Day) (Year)

8. AGE: Years **84** Months **5** Days **10** If less than one day hr. min.

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

10. Usual occupation **housewife**

11. Industry or business

MOTHER FATHER { 12. Name **William Weathers**
13. Birthplace **unknown** **unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown** **unknown**
15. Birthplace **unknown** **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Art Whitworth** (son)

(b) Address **228 West Saline, Sedalia, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11/18/44**
(Month) (Day) (Year)

(c) Place: burial or cremation **Crwon Hill Cemetery**

18. (a) Signature of funeral director **Ewing Funeral Home**

(b) Address **Sedalia, Missouri**

19. (a) **Nov. 17, 1944** (Date received local registrar) **Mrs Anna Berger** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Pettis**
(c) City or town **Sedalia**
(If outside city or town limits, write "RURAL")
(d) Street No. **228 West Saline**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
Nov. 14
20. DATE OF DEATH: Month **Nov.** day **14** year **1944** hour **2:10** minute **P.** M.
21. I hereby certify that I attended the deceased from **Sept 15**, 1944, to **Nov 14**, 1944, that I last saw her alive on **Nov 12**, 1944, and that death occurred on the date and hour stated above.
Immediate cause of death **Gangrene of one foot & senility** Duration
Due to **Endoarteritis**
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **99.2**
Of autopsy
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) (c) Means of injury **5**

23. Signature **H. I. Bishop** (M. D. or other)

Address **Sedalia Mo** Date signed **11-17-44**

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

-80
1-24-44

1022

NOV 28 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

Duane Ewing

Licensed Embalmer No.

3847

P. O. Address

Sedalia, 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.