

S. No. 2  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED DEC 22 1944**  
199

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40395**  
**4987**  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. **1002**

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Jackson City**  
(c) Name of hospital or institution **303 Bush Creek Rd.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **54 yrs.**  
In this community **54 yrs.**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Jackson**  
(c) City or town **J.C.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **none**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Charles P. Tuttle**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **12** day **3**  
year **1944** hour **11** minute **30 P.M.**

3. (b) If veteran, name war **Don't know** 3. (c) Social Security No. **Don't know**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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.

7. Birth date of deceased **unknown**  
(Month) (Day) (Year)

Immediate cause of death **seizure**

8. AGE: Years **aprox 60** Months **x** Days **x** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to **Myocardial Failure**  
Due to **1628**

9. Birthplace **Jackson City Mo**  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death)  
Major findings **History & Inspection**

10. Usual occupation **Special Agent for R.R. Express Co.**

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business **unknown**

12. Name **unknown**

13. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

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

16. (a) Informant **Coroner's Office**  
(b) Address **415 E. 12 St**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

17. (a) **Burial** (b) Date thereof **12-9-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 **5**

(c) Place: burial or cremation **Calvary Cemetery**

23. Signature **James M. Walker** (M, D, or other)  
Address **1424 Poplar Rd** Date signed **12-4-44**

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

