

V. S. No. 2  
DM-9-4-41  
Rev. 5-17-39  
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1865

U. S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 20 1945

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 412

Registration District No. 47 Primary Registration District No. 3008

14  
2

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

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town  Fulton   
(c) Name of hospital or institution: State Hospital No 1  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution 1 yr 7 m 25 d  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Miller 14  
(c) City or town  Ibouca   
(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 Robert D Whittle  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 17  
year 1944 hour 7 minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 12-1-44 19\_\_\_\_ to 12-17-44 19\_\_\_\_  
that I last saw him alive on 12-17-44 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color of race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Lucinda Whittle 6. (c) Age of husband or wife if alive Deceased years  
7. Birth date of deceased Mar 2 1861  
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis  
Due to Arteriosclerosis

8. AGE: Years 53 Months 9 Days 15  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 93 d

9. Birthplace Ibouca Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Peter J Whitten  
13. Birthplace Mo \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name Haskins  
15. Birthplace Mo \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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)  
(2) Means of Injury \_\_\_\_\_

16. (a) Informant Record  
(b) Address \_\_\_\_\_  
17. (a) Removed (b) Date thereof 12-18-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ibouca Mo  
18. (a) Signature of funeral director John Adams  
(b) Address Shiga Mo  
19. (a) 12-18-1944 (b) Josie Mouskloff  
(Date received local registrar) (Registrar's signature)

23. Signature George H Pears (M. D. or other) MD  
Address Fulton Mo Date signed 12-17-44

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 1-19-45

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 Robert L. Adams

Licensed Embalmer No. 4207

P. O. Address Shelton, 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.