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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 7 1945

Registration District No. 172

Primary Registration District No. 4272

Registrar's No. 2

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

1. PLACE OF DEATH:
 (a) County Lafayette
 (b) City or town Waverly
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Died in Dr. Jones' Office
(If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution 3
(Specify whether years, months or days)
 In this community All of his life

3. (a) PRINT FULL NAME Don Meter Hutton
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex Male
 5. Color of hair Black
 6. (a) Single, widowed, married, divorced, Married
 6. (b) Name of husband or wife Yettie Hutton
 6. (c) Age of husband or wife if alive 49 years
 7. Birth date of deceased Jan. 3 1882
(Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days 8
 If less than one day hr. 0 min. 0

9. Birthplace Chambersburg, Pa
(City, town, or county) (State or foreign country)

10. Usual occupation Teamster

11. Industry or business "

12. Name Dr. C. W. Hutton
 13. Birthplace unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Eloa Payne
 15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Yettie Hutton
 (b) Address Waverly, Mo

17. (a) Burial
(Date received local registrar) (Month) (Day) (Year)
 (b) Date thereof 1-7-45
 (c) Place: burial or cremation Waverly, Mo

18. (a) Signature of funeral director Green Stone
 (b) Address Waverly, Mo

19. (a) 1-10-1945 (b) Dr. W. A. Braechle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lafayette
 (c) City or town Waverly
(If outside city or town limits, write "RURAL")
 (d) Street No. 1
(If rural, give location)
 (e) Citizen of foreign country? No
 If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 3
 year 45 hour 3 minute 10 P.M.
 21. I hereby certify that I attended the deceased from On 1/3 1945 to 19;
 that I last saw Y alive on 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Embolism
 Due to.....
 Due to.....
 Other conditions None
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
 Of operations.....
 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) (e) Means of injury.....

23. Signature Geo Jones (M. D. or D.O.)
 Address Waverly, Mo Date signed 1/3/45

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

2-6-45

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.....

Licensed Embalmer No. 3105

P. O. Address Lexington, 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.