S. No. 2
M—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14803

Registration District No. 253

Primary Registration District No. 6185

Registrar's No. 8

1. PLACE OF DEATH:

(a) County: Texas

(b) City or town: Rural — Boone twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ✓
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Texas

(c) City or town: Rural
(If outside city or town limits, write "RURAL")

(d) Street No.: Boone twp
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: James W. Willhite

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Ethel Willhite

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: Mar (Month) 24 (Day) 1860 (Year)

8. AGE: Years 84 Months 7 Days 27 If less than one day ..... hr. ..... min.

9. Birthplace: White Co. (City, town, or county) Tenn (State or foreign country)

10. Usual occupation: Farming

11. Industry or business .....

FATHER
12. Name: Isaac Willhite
13. Birthplace: Tenn (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Melissa Howard
15. Birthplace: Tenn (City, town, or county) (State or foreign country)

16. (a) Informant: Robert L. Willhite
(b) Address: Olate Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 23, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Cadle Cem

18. (a) Signature of funeral director: Smith & Ferguson
(b) Address: Licking Mo

19. (a) 4/12 — 1945 (Date received local registrar) (b) Meyer Wilson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21 year 1944 hour 1 minute 20 P.M.

21. I hereby certify that I attended the deceased from Nov 20, 1944, to ....., 19..., that I last saw him alive on Nov 20, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apoplexy	
Due to: Chronic nephritis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 1/3/45	
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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature: Leslie Randall MD (M.D. or other)

Address: Licking Mo Date signed 4/10/45

(Licensed Embalmer's Statement on Reverse Side)

1237

RECEIVED
District Health Officer No. 5
District File Number 445219
Date Filed 7-24-45

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 Eubert E. Ferguson

Licensed Embalmer No. 3945

P. O. Address Liberty Miss

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.