

FILED SEP 11 1945

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 190

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkville Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Laughlin
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hr.
(Specify whether _____)
In this community _____
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair
(c) City or town Kirkville
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) _____
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert L. Chittick

3. (b) If veteran. _____ 3. (c) Social Security
name war World War #1 No. 718-16-0974

4. Sex Male 5. Color or race wh
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Effie Chittick 6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased 1-12-1892
(Month) (Day) (Year)

8. AGE: Years 53 Months 7 Days 5
If less than one day _____ hr. _____ min.

9. Birthplace PONTIAC ILL
(City, town, or county) (State or foreign country)

10. Usual occupation COAL MINER

11. Industry or business _____

12. Name James Chittick
13. Birthplace see 1
(City, town, or county) (State or foreign country)
14. Maiden name Frances Van Dieren
15. Birthplace see 1
(City, town, or county) (State or foreign country)

16. (a) Informant Effie Chittick

(b) Address 7011 1/2 River Mo

17. (a) Reveries (b) Date thereof 8-19-45
(Burial or cremation) (Month) (Day) (Year)
(c) Place: burial or cremation Reveries Mo

18. (a) Signature of funeral director R. S. Edwards
(b) Address Reveries Mo

19. (a) 8-24-45 (b) Dr. L. Wayne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 17
year 1945 hour 3:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Aug. 17, 1945 to Aug. 17, 1945
that I last saw him alive on Aug. 17, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Internal hemorrhage due to ruptured spleen shock.
Due to Accident in coal mine

Due to Car bucked over him crushing left side under loaded car.
Other conditions Bilobar ribcage ribs left side.
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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) Accident!

(b) Date of occurrence 8/17/45

(c) Where did injury occur? Coal mine, Reveries Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Schneider Coal mine
While at work? Yes (Specify type of place) (e) Means of injury Car crushed

23. Signature Dr. W. L. Widlich (M. D. or other) _____
Address Reveries, Mo. Date signed 8/17/45

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

MOTHER FATHER

OCT 16 1947

SEP 18 1945

SEP 12 1945

RECEIVED

District Health Officer No. 10

District File Number 9-45-379

Date Filed SEP 8 1945

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 H. G. Edwards

Licensed Embalmer No. 1961

P. O. Address Brewer 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.