

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34401**

FILED NOV 28 1945
Registration District No. **284**

Primary Registration District No. **0970**

Registrar's No. **4**

1. PLACE OF DEATH: **Polk**
(a) County **"Rural"**
(b) City or town **S. McKinley Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days.

3. (a) PRINT FULL NAME **James Willard DeWitt**
3. (b) If veteran, name war **MONZ**
3. (c) Social Security No. **NAME**

4. Sex **male** 0
5. Color or race **white**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec. 4 1861**
(Month) (Day) (Year)

8. AGE: Years **83** Months **10** Days **24**
If less than one day _____ hr. _____ min.

9. Birthplace **Tosper County Iowa**
(City, town or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business
12. Name **J.W. DeWitt**
13. Birthplace **unk** **G**
(City, town or county) (State or foreign country)
14. Maiden name **Delpha Montgomery**
15. Birthplace **unk** **G**
(City, town or county) (State or foreign country)

16. (a) Informant **Willard DeWitt**
(b) Address **Polk Mo.**

17. (a) **Burial**
(Burial, cremation, or removal) (b) Date thereof **Oct. 29, 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Gilard Cemetery**

18. (a) Signature of funeral director **Hutchison - Turpin**
(b) Address **Bellevue Mo.**

19. (a) **Oct 31 - 1945**
(Date received local registrar) (b) **Mae Zimmerman**
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Polk** **84**
(c) City or town **"Rural"** **0**
(If outside city or town limits, write "RURAL")
(d) Street No. **1111 Hickory Mo.** **0**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **28**
year **1945** hour **2** minute **30 P.M.**
21. I hereby certify that I attended the deceased from **April**
_____ 1945 to **Oct 28** 1945
that I last saw him alive on **Oct 25** 1945
and that death occurred on the date and hour stated above

Immediate cause of death **Senility**
Duration _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **162K**
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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **J. W. Zimmerman** (D. or other)
Address **Bellevue Mo.** Date signed **Mo.**

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 7,
District No. 10-45-1087
Date Filed 11-8-45

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

[Signature]

Licensed Embalmer No. 3153

P. O. Address. Bolivar, 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.