

FILED FEB 11 1946 STANDARD CERTIFICATE OF DEATH

State File No. 3096

Registration District No. 163

Primary Registration District No. 4253

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Johnson
 (b) City or town Chilhowee
 (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
 In this community 76 yrs - years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
 (c) City or town Chilhowee, Mo.
 (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 ROSA BELL KITTERMAN

3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex Female 5. Color or race white 6. (a) Single, widowed, Married, divorced Wid

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive 25 years (Month) (Day) (Year)

7. Birth date of deceased 9 25 1863
 (Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 18 If less than one day hr. min.

9. Birthplace Illinois!
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business —

12. Name Andy Calhoun

13. Birthplace Ohio!
 (City, town, or county) (State or foreign country)

14. Maiden name Nelda Moore

15. Birthplace Illinois!
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nina Burnel
 (b) Address Chilhowee, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-46
 (Month) (Day) (Year)

(c) Place: burial or cremation Providence Cemetery

18. (a) Signature of funeral director Fred Williams
 (b) Address Clinton, Mo.

19. (a) 1-16-46 (Date received local registrar) (b) Dr. R. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 13
 year 1946 hour 12:25 minute P. M.

21. I hereby certify that I attended the deceased from Dec 22
1945, to Jan 13 1946
 that I last saw her alive on Jan 13 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary pneumonia

Duration 3 1/2 wks

Due to —

Due to —

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations — Of autopsy —

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 E. N. Robinson (M. D. or other) DO
 Address Chilhowee, Mo. Date signed 1/16/46

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

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..... *Fred Wilkerson*

Licensed Embalmer No..... *2478*

P. O. Address..... *Clinton, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 726
Registrar's No. 9

Registration District No. 165 Primary Registration District No. 253

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Chilhowee
(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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Rosa B. Ketterman
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife R. Ketterman 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Sept 2 1882 (Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ and that death occurred on the date and hour stated above.
In immediate cause of death Solar pneumonia

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

Major findings: Of operations _____
Of autopsy 108
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____

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 E. N. Robinson (M. D. or other) D.O.
Address Chilhowee Date signed _____

1447 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY 3

3096