DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31053

FILED SEP 17 1946

Registrar's District No. 2 Primary Registration District No. 4364 Registrar's No.

1. PLACE OF DEATH:
(a) County McDonald Newton
(b) City or town Stella
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Stella Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community 3 days

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

3. (a) PRINT FULL NAME William Richard TRUHITTE
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 M
6. (b) Name of husband or wife Ella Truhitte
6. (c) Age of husband or wife if alive years
7. Birth date of deceased September (Month) 29 (Day) 1885 (Year)

8. AGE: Years 60 Months 10 Days 11 If less than one day -- hr. --- min.

9. Birthplace Barry Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Farmer & Merchant
11. Industry or business Farm

MOTHER FATHER
12. Name Benjamin R. Truhitte
13. Birthplace (City, town, or county) Tenn. (State or foreign country)
14. Maiden name Sureldia Guffy
15. Birthplace (City, town, or county) Ark. (State or foreign country)

16. (a) Informant Glen Truhitte
(b) Address Cassville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Sparks Cemetery
18. (a) Signature of funeral director Koon Funeral Home
(b) Address Cassville, Mo.
19. (a) 10-15-46 (Date received local registrar) (b) Alpha Oyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10th. year 1946 hour minute M.
21. I hereby certify that I attended the deceased from Aug. 27, 1932 to Aug. 10, 1946 and that I last saw him alive on Aug. 10, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Embolus	1/2 hour
Due to: Surgery for Duodenal Adhesions	3 Mo.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Duodenal adhesions	
Of autopsy: 1223	

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 2

23. Signature E. E. McQuitt (M. D.) D.O.
Address Cassville, Mo. Date signed 8/13/46.

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(Licensed Embalmer's Statement on Reverse Side)

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 W. C. Koon

Licensed Embalmer No. 4359

P. O. Address Cassville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6c4

Registration District No. 243 Primary Registration District No. 436 Registrar's No. 34

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Stella
(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 (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

3. (a) PRINT FULL NAME William R. Trubitte
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 29 (Day) 1886 (Year)

8. AGE: Years 60 Months 10 Days Yrs. Less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 10-15-40 (Date received local registrar) (b) Alpha Dyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 29 Day 1946 year hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions
(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)
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—WRITE A FIRMLY

31053