

**FILED OCT 8 1946**

Registration District No. **275**

Primary Registration District No. **3053**

Registrar's No. **133**

1. PLACE OF DEATH:  
(a) County **Phelps**  
(b) City or town **Rolla**  
(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 **12 yrs.** (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME **William M. Whitaker**  
3. (b) If veteran, name war **-**  
3. (c) Social Security No. **-**

4. Sex **Male** 5. Color or race **Wh**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **MARY M. WHITAKER**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **JANUARY 30 1853**  
(Month) (Day) (Year)

8. AGE: Years **93** Months **8** Days **0**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **PULASKI Co., KENTUCKY**  
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMING**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **John Whitaker**

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

14. Maiden name **MARGARET DIASON**

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

16. (a) Informant **MRS. L. E. WATTS**

(b) Address **WATTS DRIVE - ROLLA MO**

17. (a) **BURIAL** (b) Date thereof **10-3-1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Smith Cemetery**

18. (a) Signature of funeral director **W. L. S. J. H.**

(b) Address **508 W 8th ROLLA MO**

19. (a) **OCT. 3, 1946** (b) **W. J. HARVEY**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **30**  
year **1946** hour **4** minute **-** P. M.  
21. I hereby certify that I attended the deceased from **Sept 24** 1946 to **Sept 30** 1946  
that I last saw him alive on **Sept 30** 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death **Shock following fracture of left hip** Duration \_\_\_\_\_

Due to **Senility**  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature **W. J. Harvey** (M.D. or Other)  
Address **Rolla Mo** Date signed **10/2/46**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

252

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.....

*Jessie B. Abernathy*....., Registered Apprentice No. *419*  
working under my personal supervision.

Signed *S. B. [Signature]*.....

Licensed Embalmer No. *3397*

P. O. Address *Roller 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.**

Registration District No. 275 Primary Registration District No. 3053

1. PLACE OF DEATH:  
(a) County Phelps  
(b) City or town Rolla  
(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 William M. Whitaker  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race N 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 93 Months 8 Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER { 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 \_\_\_\_\_  
(a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
(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 Sept year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence 9-27-46  
(c) Where did injury occur? Rolla, Phelps Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home  
While at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ means of injury Fell on floor  
23. Signature Arthur Whitaker (M. D. or other) \_\_\_\_\_  
Address Rolla Mo Date signed 10-14-46

**SUPPLEMENTARY**

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

8990

31139