. No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5821

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 55

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Woodland Hospital
(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 Missouri (b) County Randolph

(c) City or town Moberly
(If outside city or town limits, write "RURAL")

(d) Street No. 418 Franklin Ave
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Thomas Wm Chittenden

3. (b) If veteran, name war ✓

3. (c) Social Security No. .....

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Crystal

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Feb (Month) 24th (Day) 1906 (Year)

8. AGE: Years 41 Months — Days 7 If less than one day ..... hr. ..... min.

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

10. Usual occupation District Supt.

11. Industry or business Continental Oil Co

MOTHER FATHER

12. Name Herbert Chittenden

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

14. Maiden name Susan Broomfield

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

16. (a) Informant Mrs. Crystal Chittendem

(b) Address Moberly Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Mch 2-47 (Month) (Day) (Year)

(c) Place: burial or cremation Hays. Kas

18. (a) Signature of funeral director Maran and Son

(b) Address Moberly Mo

19. (a) Mar 2-47 (Date received local registrar) (b) Leah Williams Lowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st year 1947 hour 6 minute 20 A.M.

21. I hereby certify that I attended the deceased from 28 ~~March~~ Feb 1947, to 1st Mar 1947 that I last saw him alive on 1 March 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Massive intracranial injury - Skull fracture	48 hours
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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 28 Feb-47

(c) Where did injury occur? Keytesville, Chariton Mo (City or town) (County) (State)

(d) Did injury occur in or about home or farm, in industrial place, in public place? Public highway

While at work? No (Specify type of place) (e) Means of injury Auto accident

23. Signature H. Fowler (M. D. or other) MD

Address Woodland Hosp. Date signed 2 Mar

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(Licensed Embalmer's Statement on Reverse Side)

Coll. with other Motor Vehicle

FEB 16 1948

RECEIVED
Health Officer No. 10
MAR 11 1947

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 Frank D DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly 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.