

No. 2
-1/47
-17-39
X

State File No.

National Office of Vital Statistics

FILED OCT 7 1947

Registrar's No. 260

Registration District No.

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Community Nursing Home #1 #
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 2 years
(Specify whether years, months or days)
In this community Most of Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 98
(c) City or town Greentop 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Samuel Britt

3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex M O 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Dora Isabel Crow
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. 25 1856
(Month) (Day) (Year)

8. AGE: Years 90 Months 11 Days 24
If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

12. Name Evan Britt

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

14. Maiden name Frances Thompson

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

16. (a) Informant Mrs. Violet Robinson

(b) Address Greentop, Missouri

17. (a) Burial (b) Date thereof 9/21/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ft. Madison Cmt.

18. (a) Signature of funeral director DEE Raley

(b) Address Kirksville, Missouri

19. (a) Sept 30-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1947 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from 7:16 P
1947 to Sept 19, 1947
that I last saw him alive on Sept 19, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive pneumonia 1 day
Due to Myocardial weakness year
Due to Atherosclerosis years
Other conditions Multiplicity of none 3 years
(include pregnancy within 3 months of death)

PHYSICIAN
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? (Specify type of place)
While at work? (c) Means of injury
23. Signature M. T. Cutler (M.D. or other) DO
Address Kirksville, Mo Date signed 9-19-47

ADD TO DEATH SUPPLEMENTARY INFORMATION REQUESTED

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

MOTHER FATHER

RECEIVED

District Health Officer No.

District File Number 10-47-12

Date Filed OCT - 5 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 D. E. Riley

Licensed Embalmer No. 4181

P. O. Address Kirksville, 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.

S. No. 2D
M-345
EX-3880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. act

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 260

1. PLACE OF DEATH:
 (a) County Adair
 (b) City or town Kirkville
 (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 _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME Samuel Britt
 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 married
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased Sept. 25 1892
 (Month) (Day) (Year)

8. AGE: Years 90 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 { 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 _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (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 Sept Day _____
 year 1982 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 spontaneous pneumonia
myocardial weakness
arteriosclerosis
 Other conditions cancer of nose
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations 53
 Of autopsy _____
 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)
 23. Signature M. T. Hutcheson, D.O. (a) Means of injury _____
 Address Kirkville, Mo Date signed 10-5-82

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

SUPPLEMENTARY

S-30193