

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 355

Primary Registration District No. 6202

Registrar's No.

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Summersville route 1 Carroll
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 2 1/2 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Texas 107
(c) City or town route #1 Summersville
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Eula Mae Whittington

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 married
6. (b) Name of husband or wife roy Whittington 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Nov 19 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 11 11 _____ hr. _____ min.

9. Birthplace Anderson Co. Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name unknown
13. Birthplace _____ (City, town, or county) (State or foreign country) 9
14. Maiden name unknown
15. Birthplace _____ (City, town, or county) (State or foreign country) 9

16. (a) Informant roy Whittington
(b) Address Summersville, Mo

17. (a) Burial (b) Date thereof 11 3 47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director Luncan Funeral Home
(b) Address Mountain View, Mo.

19. (a) _____
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1
year 1947 hour 12 minute 10 a.m.

21. I hereby certify that I attended the deceased from Oct 28, 1947, to Oct 28, 1947;
that I last saw him alive on Oct 28, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Central thrombosis 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? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature Stanley Barnum (M. D. or other) DD
Address 1100 S. Main St. Springfield, Mo. Date signed 12-9-47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File No. 14-8641

Date Filed 1-29-48

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 Joe R. Duncan

Licensed Embalmer No. 4325

P. O. Address W. View, Md.

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.