

S. No. 2  
M-43  
5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 26 1948

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8393  
Registrar's No. 574

Registration District No. 114 Primary Registration District No. 5437

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

1. PLACE OF DEATH:  
(a) County Franklin  
(b) City or town Rural Meramec Twsp.  
(c) Name of hospital or institution: Sullivan  
(d) Length of stay: In hospital or institution 23 Days - Spc  
In this community 23 Days - Spc (Specify whether years, months or days)

3. (a) PRINT FULL NAME James Oliver Witt  
(b) If veteran, name war XX  
(c) Social Security No. XX

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Infant  
6. (b) Name of husband or wife XX  
6. (c) Age of husband or wife if alive XX years  
7. Birth date of deceased Feb. 21 1948  
(Month) (Day) (Year)

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

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

10. Usual occupation XX

11. Industry or business XX

MOTHER FATHER { 12. Name James Walter Witt  
13. Birthplace Sullivan, Mo.  
14. Maiden name Ruby Geraldine Williams  
15. Birthplace Salem Mo.

16. (a) Informant James W. Witt  
(b) Address Sullivan, Mo.

17. (a) Burial (b) Date thereof 3/16/48  
(c) Place: burial or cremation I.O.O.F. Sullivan, Mo.

18. (a) Signature of funeral director  
(b) Address 65 N. Clark Ave

19. (a) 3-16-48 (b) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Franklin  
(c) City or town Rural  
(d) Street No.  
(e) Citizen of foreign country? No.  
If yes, name country.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 15  
year 1948 hour 1 minute P. M.  
21. I hereby certify that I attended the deceased from 3-11-48 to 3-12-48  
that I last saw him alive on 3-11-48 and that death occurred on the date and hour stated above.

Immediate cause of death malnutrition  
Due to under feeding

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations 158  
Of autopsy 158

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

23. Signature of Physician O. P. Santos  
Address Sullivan Mo Date signed 3/16/48

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed MAR 25 1948

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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Robert M. Murray  
Licensed Embalmer No. 3749  
P. O. Address Sullivan, 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.