

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

18809

State File No. \_\_\_\_\_

FILED JUL 9 1948

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 215

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1431 (Rear) North Main St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life Time years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler  
(c) City or town Poplar Bluff Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1431 (Rear) North Main  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME Marion H. Whittington  
3: (b) If veteran, name war \_\_\_\_\_ 3: (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18  
year 1948 hour 3:05 minute P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb. 18, 1874  
(Month) (Day) (Year)

Immediate cause of death Asphyxiation Duration \_\_\_\_\_  
cardiac failure  
cardio-vascular-renal disease  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 74 Months 4 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Butler Co., Mo (City, town, or county) (State or foreign country)  
10. Usual occupation Retired Farmer

Major findings: Of operations 13/10  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name Tom Whittington  
13. Birthplace Vincennes, Ind (City, town, or county) (State or foreign country)  
14. Maiden name Betty Craft  
15. Birthplace Mo (City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Tom Swafford  
(b) Address Poplar Bluff, Mo  
17. (a) Butler (b) Date thereof 6-19-48 (Month) (Day) (Year)  
(c) Place: burial or cremation Hillis - Butler Co., Mo  
18. (a) Signature of funeral director Frank Cotrell  
(b) Address Poplar Bluff, Mo  
19. (a) 6/30/48 (b) [Signature] (Date received local registrar) (Registrar's signature)

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 [Signature] (M.D. or other) \_\_\_\_\_  
Address Poplar Bluff, Mo Date signed \_\_\_\_\_

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

RECEIVED

District Health Office No. 2,

District File Number 748-824

Date Filed 7-6-48

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.....

John M. Davies....., Registered Apprentice No. 487  
working under my personal supervision.

Signed Scott A. Collett.....

Licensed Embalmer No. 3567

P. O. Address Poplar Bluff, 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.