

FILED MAR 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7292

BIRTH NO. _____		REG. DIST. NO. <u>10</u>		PRIMARY REG. DIST. NO. <u>3002</u>		Registrar's No. <u>42</u>		
1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>Mexico</u>		c. LENGTH OF STAY (in this place) <u>2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural</u>		0 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Audrain Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>5 mi. S.E of Wellsville Mo.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>J.</u> c. (Last) <u>Chittum</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March - 6 - 1949</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April - 19 - 1873</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u>	IF UNDER 48 HRS. Hours <u>18</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (State or foreign country) <u>Center, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13a. FATHER'S NAME <u>Wm Chittum - Sr</u>			13b. MOTHER'S MAIDEN NAME <u>Ann Epperson</u>		14. NAME OF HUSBAND OR WIFE <u>Jennie Chittum</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Monta Hagar - Wellsville, Mo.</u>				
18. NO. OF DEATH. Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Prostatic - Cystic Urinary retention.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>6/1/49</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>March 3, 1949</u> , to <u>March 6, 1949</u> , that I last saw the deceased alive on <u>March 6, 1949</u> , and that death occurred at <u>8:40 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Dr. Frank J. Kelly, M.D.</u>				23b. ADDRESS <u>Mexico, Mo.</u>		23c. DATE SIGNED <u>Mar 6/49</u>		
24a. BURIAL/CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>March 7</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Center, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Mar-7-1949</u>		REGISTRAR'S SIGNATURE <u>Blanche Neely</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clyde C. Hilkey Laddonia, Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

RECEIVED

District Health Officer No.

District File Number 3.49

Date Filed MAR-16-1949

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 E. Maxwell Student Embalmer No. 252
working under my personal supervision.

Student John E. Maxwell Signed John F. Ellis
Student Embalmer Licensed Embalmer No. 4613

P. O. Address Peru, 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.