

FILED OCT 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

342773

State File No.

 BIRTH NO. _____ REG. DIST. NO. 171 PRIMARY REG. DIST. NO. 5637 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>R.F.D. Odessa "Clay Twp"</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Clay Twp</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D. Odessa</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>THOMAS ELLSWORTH</u>	b. (Middle) <u>KITE</u>	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 30, 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 9, 1893</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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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>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Mo. R.F.D. Odessa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>H. D. Kite</u>	13b. MOTHER'S MAIDEN NAME <u>**--Lockhart</u>	14. NAME OF HUSBAND OR WIFE <u>Gertrude Kite</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>487-1609983</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Gertrude Kite</u>	ADDRESS <u>R.F.D. Odessa</u>
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18. CAUSE 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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>153 X</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		

19a. DATE OF OPERATION <u>1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>Cancer</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Jan 1946, to Sept 30, 1949 that I last saw the deceased alive on Sept 12, 1949, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ben H. Brasher M.D.</u>	23b. ADDRESS <u>Lexington Mo</u>	23c. DATE SIGNED <u>10-3-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/1/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greeton</u>	24d. LOCATION (City, town, or county) (State) <u>Wellington Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Oct. 1-1949</u>	REGISTRAR'S SIGNATURE <u>Letta Drummond</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Claire Sheppard</u>	ADDRESS <u>Wellington, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8, ^{OCT 14}

District File Number _____

Date Filed 10-15-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed J. Clair Sheppard

Licensed Embalmer No. 4179

P. O. Address Washington, 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.