

FILED APR 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7916**

0164
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BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **102**

1. PLACE OF DEATH a. COUNTY Cape County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) Cape Girardeau		c. CITY (If outside corporate limits, write RURAL and give township) TallaPOOSA	
c. LENGTH OF STAY (In this place) 8 DAYS		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION South East Missouri			

3. NAME OF DECEASED a. (First) Adam b. (Middle) Alonso c. (Last) Littell			4. DATE OF DEATH (Month) (Day) (Year) Feb 23 50		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 11/16/1870	9. AGE (In years last birthday) 79	10. UNDER 1 YEAR Months 3 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gro. Store		11. BIRTHPLACE (State or foreign country) Malden Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.					

13a. FATHER'S NAME Adam Alonso Littell		13b. MOTHER'S MAIDEN NAME NOT KNOWN		14. NAME OF HUSBAND OR WIFE Addie May Littell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Arthur E. Littell TallaPOOSA Mo.	
				ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis			INTERVAL BETWEEN ONSET AND DEATH 2 years	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Advanced age				
		DUE TO (c)				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4222	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., to 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?	
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22. I hereby certify that I attended the deceased from **2/16**, 19**50**, to **2/22**, 19**50**, that I last saw the deceased alive on **2/22**, 19**50**, and that death occurred at **7:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]		23b. ADDRESS [Address]		23c. DATE SIGNED 2/23/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2/26/50		24c. NAME OF CEMETERY OR CREMATORY Malden		24d. LOCATION (City, town, or county) (State) Malden Mo.	
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DATE REC'D BY LOCAL REG. 3-27-1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS	
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(Licensed Embalmer's Statement on Reverse Side)

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

APR 13 1950

RECEIVED

APR 3 1950

DISTRICT HEALTH OFFICE No. 4

File No. 450-480

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

working under my personal supervision.

Student Embalmer No.

Signed

Lloyd Russell

Signed.....
Student Embalmer

Licensed Embalmer No. 509 art

P. O. Address Piggott Hart

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.