

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22564

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 78 PRIMARY REG. DIST. NO. 4165 Registrar's No. 69

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gallatin</u>		c. CITY OR TOWN <u>Gallatin</u>	d. Residence within limits of a city of incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>2 Weeks</u>		e. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Sullivan Rest Home</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Beatrice</u>	b. (Middle) <u>Moore</u>	c. (Last) <u>Whitt</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 12 1954</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 4 1863</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Daviess Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			

13a. FATHER'S NAME <u>Archie Youtsey</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth George</u>	14. NAME OF HUSBAND OR WIFE <u>Wm. E. Whitt (Dec'd)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Sam Youtsey, Jameson, Missouri</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</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>Senility</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	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) <u>331X</u>
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? _____

22. I hereby certify that I attended the deceased from Nov 7, 1947, to July 12, 1954, that I last saw the deceased alive on July 11, 1954, and that death occurred at 4:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Fred H. Wilson M.D.</u>	23b. ADDRESS <u>Winston Mo</u>	23c. DATE SIGNED <u>7/13-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-14-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Centenary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Daviess Co. Missouri</u>
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DATE REC'D BY LOCAL REG. <u>7-21-54</u>	REGISTRAR'S SIGNATURE <u>Virginia M. Engelhart</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hope Funeral Home, Gallatin, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0310

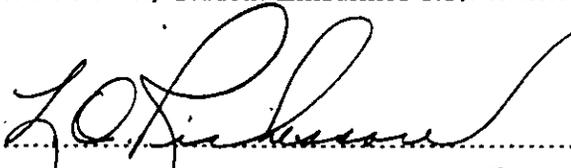
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STATEMENT BY LICENSED EMBALMER

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.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No. 330

P. O. Address Fall River

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.