

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008981
STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 79

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SULLIVAN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSP. 2 DAYS		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) DIVISION ST.
3. NAME OF DECEASED (Type or print) First Middle Last WILL WITT			4. DATE OF DEATH Month Day Year MARCH 30, 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 6, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	9. AGE (In years last birthday) 57
11. BIRTHPLACE (City and state or country) WASHINGTON Co. Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME RICHARD WITT		13b. MOTHER'S MAIDEN NAME FRANCIS YARBROUGH	14. NAME OF HUSBAND OR WIFE MABEL HAMM
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. 499-12-3054	17. INFORMANT Address MABEL WITF, SULLIVAN, MO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis DUE TO (b) Ruptured Colon DUE TO (c) Thrombosis of Right Colic Artery PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acicular Fibillation			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Days 1 1/2 Days 1 1/2 Days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1956 to Mar 30 - 59 and last saw him alive on Mar 30 - 1959 Death occurred at 8:25 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert J. [Signature]		22b. ADDRESS Sullivan, Mo.	
22c. DATE SIGNED Mar 31 - 59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/2/59	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. CEMETERY	23d. LOCATION (City, town, or county) (State) SULLIVAN MO
24. FUNERAL DIRECTOR H. M. EATON, SULLIVAN, MO		25. DATE RECD. BY LOCAL REG. 4/2/59	26. REGISTRAR'S SIGNATURE [Signature]

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. A. Humphrey*

Licensed Embalmer No. *4772*

P. O. Address *Sullivan, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.