

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 315

FILED NOV 15 1943  
Registration District No. 274

Primary Registration District No. 3052

80  
6  
4

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

1. PLACE OF DEATH:

(a) County PETTIS

(b) City or town SEDALIA  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 903 S. KENTUCKY  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 MONTHS (Specify whether years, months or days)

In this community 9 MONTHS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County PETTIS MO

(c) City or town SEDALIA  
(If outside city or town limits, write "RURAL")

(d) Street No. 903 - S. KENTUCKY  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME AMBROSE BURNSIDE WITT

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 0

5. Color or race WHITE 0

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 2 11 1865  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>7</u>	<u>22</u>	hr. _____ min. _____

9. Birthplace IRWIN KY.  
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name FRANCIS M. WITT

13. Birthplace IRVIN KY  
(City, town, or county) (State or foreign country)

14. Maiden name ARMILDA

15. Birthplace WINCHESTER KY  
(City, town, or county) (State or foreign country)

16. (a) Informant WALTER WITT

(b) Address SEDALIA, MO.

17. (a) BURIAL (b) Date thereof 10-5-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALHOUN, MO.

18. (a) Signature of funeral director Gillespie

(b) Address SEDALIA MO.

19. (a) 10/4/43 (b) Anna Berger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 3RD  
year 1943 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 10 1943 to Oct 3 1943  
that I last saw him alive on Oct 2 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus Duration 2 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 61  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Robert R. Sturges (M.D. or other) Do

Address Sedalia mo Date signed 10-4-43

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

11-2-43

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed L. E. Bouldin

Licensed Embalmer No. 3867

P. O. Address SEDALIA, 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.