

U. S. No. 2  
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Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED APR 5 1945

Registration District No. 362

Primary Registration District No. 6232

Registrar's No. 11

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

1. PLACE OF DEATH:

(a) County Warren Co.

(b) City or town McKittrick, Mo. Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: XX  
Bridgeport Hosp. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
In this community 86-2-17 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Warren Co.

(c) City or town McKittrick, Mo. Rural  
(If outside city or town limits, write "RURAL.")

(d) Street No. Bridgeport Hosp  
(If rural, give location)

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

3. (a) PRINT Kittie Claborn,  
FULL NAME

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female

5. Color or race Colored

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

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

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

7. Birth date of deceased Dec 25 th 1888  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12th  
year 1945 hour 10:55 minute AM

21. I hereby certify that I attended the deceased from March 2  
1945 to March 12, 1945  
that I last saw her alive on March 8, 1945  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>2</u>	<u>17</u>	hr. min.

Immediate cause of death Bronchial Pneumonia Duration 10 days

9. Birthplace Burgess Warren Co MO  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Due to.....

Due to.....

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

11. Industry or business.....

12. Name Albert Paene

13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Johna Culpom

15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations.....

Of autopsy.....

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

16. (a) Informant Nettie A Ritter

(b) Address McKittrick Mo

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

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

17. (a) Burial (b) Date thereof March 12th  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shutice Cemetery

18. (a) Signature of funeral director John A. Bebermeyer

(b) Address American Mo.

19. (a) Mar 12 1945 (b) John A. Bebermeyer  
(Date received local registrar) (Registrar's signature)

(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 J. J. Kersling (M. D. or other).....  
Address Herrmann Mo Date signed 3-12-45

RECEIVED

District Health Officer No. 9.

District File Number

Date Filed 4-6-45

MAY 28 1945

**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.....  
D. B. Baker,....., Registered Apprentice No.....  
working under my personal supervision.

Signed D. B. Baker

Licensed Embalmer No. 3375

P. O. Address.....

**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.**