

No. 2
1-2-43
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

33000

STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 6 1945
Registration District No. H

Primary Registration District No. 4012

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Atchison

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

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME Etta Rosetta Witham

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. - 3, 1945
year _____ hour 2:00 minute 30 M.

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased March 29 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. - 13 - 1945 to Oct. 3 - 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Valvular incompetency Duration 2 yrs.

8. AGE: Years 84 Months 6 Days 4 If less than one day _____ hr. _____ min.

Due to Arterio sclerosis and dilitation of heart 3 yrs.
2 yrs.

9. Birthplace Atchison Co 0
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation _____

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

11. Industry or business _____

MOTHER FATHER { 12. Name John Rundle

13. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

14. Maiden name Matilda Rush

15. Birthplace unknown 0
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy 950

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

16. (a) Informant Bob Witham

(b) Address Rock Port mo

17. (a) burial (b) Date thereof Oct 5 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hunter cemetery - Rockport mo

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? _____

18. (a) Signature of funeral director C. G. Bertram

(b) Address Rock Port mo

19. (a) Oct 5 - 1945 (b) Betty Crabtree
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury D

23. Signature J. M. Davis (M. D. or other) _____
Address Warrio Mo Date signed 10-5-45

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

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.....

C. E. Burton....., Registered Apprentice No.....

working under my personal supervision.

Signed *C. E. Burton*.....

Licensed Embalmer No. *1764*.....

P. O. Address *Rock Port Mo.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 4

Primary Registration District No. 4012

Registrar's No. _____

1. PLACE OF DEATH, Atchison
 (a) County Atchison
 (b) City or town Rockport
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Etta R. Whitham
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased mar 29
(Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation 7 mo.

11. Industry or business _____

12. Name John Rundle

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

14. Maiden name Metilda Rusk

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct 5 1945 Betty Crabb
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY 3

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

11/10/45

33000