

S. No. 2
DM-8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12810**

FILED MAY 7 1947

Registration District No. _____

Primary Registration District No. **4124**

Registrar's No. **16**

1. PLACE OF DEATH:

(a) County **Clark**
(b) City or town **Kahoka**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home**
(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 **B. F. DEWITT**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Carrie** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **April 21 1881**
(Month) (Day) (Year)

8. AGE: Years **66** Months **6** Days **6** If less than one day hr. min.

9. Birthplace **Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **H. M. De Witt 0**

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

14. Maiden name **Kathryn Shortz**

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

16. (a) Informant **Adrian De Witt**

(b) Address **Kahoka**

17. (a) **Burial** (b) Date thereof **April 19 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kahoka Cem.**

18. (a) Signature of funeral director **Walter J. ...**

(b) Address **Kahoka Mo**

19. (a) **4-29-47** (b) **J. B. ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clark 23**
(c) City or town **Kahoka**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **27**
year **1947** hour **10:50** minute **A.M.**

21. I hereby certify that I attended the deceased from **April 25** 19**47** to **April 27** 19**47**
that I last saw h. i. m. alive on **April 27** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis ?**

Due to _____

Due to **Mitral Regurgitation ?**

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

Major findings: Of operations **A2 B3**
Of autopsy _____

Duration
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 **2**

23. Signature **D. E. White** (M. D. or other) **MD**
Address **Kahoka, Mo.** Date signed **4/28/47**

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

3
1
0

RECEIVED
District Health Officer No. 10
District No. 47.783
Date - MAY - 5 - 1947

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 Alis L. Gething
Licensed Embalmer No. 2965
P. O. Address Wray

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.