Health, Welfare Public Service

300 0
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 19754

FILED JUN 3 1957 Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 94

1. PLACE OF DEATH
a. COUNTY Saline
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Fitzgibbon Hosp. — Length of stay in 1b 9 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Saline
c. CITY OR TOWN Gilliam 0970 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First Joe Middle Edmond Last Whittle

4. DATE OF DEATH Month May Day 26, Year 1957

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X 3

8. DATE OF BIRTH Nov.20,1871

9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mail messenger

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (City and state or country) Saline County near Glasgow, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edmond Whittle

14. MOTHER'S MAIDEN NAME Mary Ann Mc Mellen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 725-16-7070

17. INFORMANT Joe S. Whittle, Address 3545 Nottingham Chicago, Illinois

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 7 days.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 490X

19. WAS AUTOPSY PERFORMED? YES ☐ NO X 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 May 18 57, to May 26 57 and last saw her/him alive on May 26
Death occurred at 3:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Bt. Kimball Jr. MD

22b. ADDRESS Marshall Mo

22c. DATE SIGNED 6/28

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 5-28-1957

23c. NAME OF CEMETERY OR CREMATORY Gilliam

23d. LOCATION (City, town, or county) (State) Gilliam, Missouri

24. FUNERAL DIRECTOR ADDRESS Haines Funeral Home, Slater, Mo.

25. DATE RECD. BY LOCAL REG. 5-31-57

26. REGISTRAR'S SIGNATURE Cecil G. Read

(Licensed Embalmer's Statement on Reverse Side)

JUL 22 1967

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Walter J. Haines Jr

Licensed Embalmer No. 4 5

P. O. Address Slater

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.