

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

AUG 15 1941

State File No. _____

R District No. 217

Primary Registration District No. 4128

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Bole

(b) City or town Centertown
(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 _____
years, months or days

In this community 40 year 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe

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

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

(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME Almada Hutchinson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 41 hour 5 minute A.M.

4. Sex Female

5. Color or race N

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 Sept 20 1855
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1 1941 to June 14 1941
that I last saw her alive on June 14 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis 1 wk.

Duration _____

8. AGE: Years 85 Months 8 Days 26
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

Other conditions (Include pregnancy within 3 months of death) 94 W

10. Usual occupation _____

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

MOTHER FATHER { 12. Name Washington Hutchinson

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

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

14. Maiden name Anna Charles
(City, town, or county) (State or foreign country)

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

16. (a) Informant Harley Hutchinson

(b) Address Centertown Mo

17. (a) Burial (b) Date thereof 6/17/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centertown Cem

18. (a) Signature of funeral director William Fredmeyer

(b) Address California Mo

19. (a) June 14 1941 (b) W. Withour
(Date received local registrar) (Registrar's signature)

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 W. Withour (M. D. or other) W. O.

Address California Date signed 6/16/41

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.....

H. E. Friedmeyer

Licensed Embalmer No.....

P. O. Address.....

2854

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24887
Registrar's No. 11

Registration District No. 211

Primary Registration District No. 4128

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

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Centertown
(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 Almada Hutchinson

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 S

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

7. Birth date of deceased _____
(Month) (Day) (Year)

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

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

10. Usual occupation Housewife

11. Industry or business Own Name

12. Name _____

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

14. Maiden name _____

15. Birthplace _____
(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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 19____;
that I first 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)

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

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

S-24887