

APR 23 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

11756

Do not use this space.

1. PLACE OF DEATH

(a) County Montana Registration District No. 574 577  
(b) Township Lima 2 Primary Registration District No. 4338  
(c) City 0 (d) Street No. 0 (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 321 Pleasant Hutchinson  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Alpha Hutchinson  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/31/40  
7. AGE YEARS 03 MONTHS 1 DAYS 13 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) North Carolina (STATE OR COUNTRY) Stokes county

13. NAME And Hutchinson  
14. BIRTHPLACE (CITY OR TOWN) Chickasaw (STATE OR COUNTRY) OK

15. MAIDEN NAME Alpha Hegner  
16. BIRTHPLACE (CITY OR TOWN) Montana (STATE OR COUNTRY) 0

17. INFORMANT (ADDRESS) A. H. Hutchinson

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Bethel DATE April 2 1940

19. FUNERAL DIRECTOR (NAME) Chas. F. Fitch (ADDRESS)

20. FILED April 1 1940 Abbie Brial Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/31 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan. 6 1940, to 3/31 1940.

I last saw him alive on Jan. 6 1940. Death is said to have occurred on the date stated above, at 7:00 P.M.

The principal cause of death and related causes of importance were as follows:

Mitral Regurgitation. Date of onset not known.

Other contributory causes of importance:

Bronchitis Date of onset not known.

Name of operation None Date of clinical No. 1  
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury ----- 19-----

Where did injury occur? (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury -----  
Nature of injury -----

24. Was disease or injury in any way related to occupation of deceased? NO  
If so, specify -----

(Signed) B. R. Reginald Dr. James Lane Mo.  
(Address) 511

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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.....

*W. B. Friedman*

Licensed Embalmer No. *2854*

P. O. Address *California Mo.*

**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, above space should be left blank.**

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11751

Registration District No. 374

Primary Registration District No. 5772A

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Moniteau  
(b) City or town Linn  
(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

Pleas Hutchison

3. (b) If veteran,  
name war \_\_\_\_\_

3. (c) Social Security  
No. \_\_\_\_\_

4. Sex m

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 FEB.  
(Month)

18  
(Day)

1847  
(Year)

8. AGE:

Years  
93

Months  
1

Days  
13

If less than one day  
\_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) April 1 1940 (b) Abbie O'neal  
(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) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 3 day 31  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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 P. A. Reynolds (M. D. or other) \_\_\_\_\_  
Address James town Date signed Jan 2

11756 (1940)