DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10304

APR 9 1941

Registration District No. 138

Primary Registration District No. 4078

Registrar's No. 878

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

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Norborne Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Dr. Cole Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution five days. (Specify whether
In this community Twenty Four Years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Norborne Mo 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 Nature years.

3. (a) PRINT FULL NAME Henry Witte

3. (b) If veteran, name war World 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 Mrs. Freida Witte 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased 2. (Month) 20 (Day) 1896 (Year)

8. AGE: Years 45 Months 1 Days 26 If less than one day ____ hr. ____ min.

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

10. Usual occupation Wounded war Vet

11. Industry or business World war

MOTHER FATHER

12. Name Detrie Witte

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

14. Maiden name Sophia Witte

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

16. (a) Informant Mrs Freida Witte

(b) Address Norborne Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 30 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Fairhaven

18. (a) Signature of funeral director John H Deitch

(b) Address Norborne Mo. 122

19. (a) 3-29-41 (Date received local registrar) (b) B. Cole (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 28 year 1941 hour 11 minute 30 P M.

21. I hereby certify that I attended the deceased from 3-2- , 1941, to 3-28- , 1941, that I last saw him alive on 3-28- , 1941, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Multiple Brain Abscesses.	3 Days
Due to Chronic Infection	2 Weeks
Due to Influenza.	3 Weeks
Other conditions (Include pregnancy within 3 months of death) 33	

Major findings: Of operations Craniectomy

Of autopsy No

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature B. Cole (M. D. or other) 11

Address Norborne Mo Date signed 3-29-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 4-7-41
Date Filed

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed John G. Deitch

Licensed Embalmer No. 3654

P. O. Address Norborne Mo

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

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